

# **Important Benefit Information Enclosed**

***2013 Group  
Evidence of Coverage***



## Table of Contents

<b>Introduction .....</b>	<b>2</b>	Limitations.....	24
Welcome to Kaiser Permanente .....	2	Reductions .....	25
About This Evidence of Coverage (EOC) .....	2	<b>Getting Assistance, Claims and Appeals Procedure, and Dispute Resolution .....</b>	<b>29</b>
Member Rights and Responsibilities .....	2	Getting Assistance .....	29
<b>Eligibility and Enrollment.....</b>	<b>4</b>	Claims and Appeals Procedure .....	29
Who Is Eligible .....	4	Dispute Resolution.....	40
Enrollment and Effective Date of Coverage .....	5	<b>Termination of Membership.....</b>	<b>40</b>
<b>How to Obtain Services.....</b>	<b>7</b>	Termination Due to Loss of Eligibility.....	41
Your Primary Care Physician.....	8	Termination of Group Agreement.....	41
Getting a Referral.....	8	Termination for Cause.....	41
Second Opinions .....	9	Termination for Fraud or Intentional Misrepresentation .....	41
Plan Facilities.....	9	Termination for Nonpayment .....	41
Getting the Care You Need.....	9	Failure of Contribution or Participation Requirements by Employer Groups .....	41
Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas .....	9	Termination for Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area .....	41
Using Your Identification Card.....	10	Termination for Movement Outside the Service Area.....	41
<b>Benefits .....</b>	<b>10</b>	Termination for Noncompliance with Medicare Membership Requirements.....	42
Outpatient Care .....	11	Discontinuation of a Product or All Products .....	42
Hospital Inpatient Care .....	11	Continuation of Group Coverage Under Federal Law (COBRA) .....	42
Ambulance.....	12	Continuation of Group Coverage Under State Law ...	42
Chemical Dependency Services .....	13	Continuation of Coverage for Reservists.....	42
Dialysis.....	13	USERRA (Uniformed Services Employment and Reemployment Rights Act) .....	43
Drugs and Supplies.....	13	Conversion of Membership .....	43
Durable Medical Equipment (DME), External Prosthetics, and Orthotics .....	14	Federally Eligible Individual .....	43
Emergency Services .....	15	<b>Miscellaneous Provisions .....</b>	<b>44</b>
Family Planning.....	16	<b>Definitions .....</b>	<b>46</b>
Hearing.....	16	<b>Appendix .....</b>	<b>48</b>
Home Health.....	16	Utilization Review .....	48
Hospice.....	17	Small Group Waiting Periods.....	49
Infertility Services .....	17	When Medicare Is Primary and Secondary.....	49
Laboratory, X-ray, and Other Diagnostic Services.....	18	<b>Deductible, Copayments and Out-of-Pocket Maximum .....</b>	<b>50</b>
Mental Health Services.....	18	Deductible .....	50
Outpatient Physical, Occupational, and Speech Therapy, Cardiac and Multidisciplinary Rehabilitation .....	19	Copayments.....	51
Preventive Exams and Services.....	19	Annual Out-of-Pocket Maximum.....	51
Prosthetic Devices (Internally Implanted) .....	21	<b>Additional Information or Other Benefits Requested by Your Group .....</b>	
Reconstructive Surgery.....	21		
Skilled Nursing Facility Services .....	21		
Transplant Services .....	21		
Urgent Care Services.....	22		
Vision Services .....	22		
<b>General Exclusions/Limitations/Reductions.....</b>	<b>22</b>		
Exclusions.....	22		

**Notice: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the “Coordination of Benefits” section, and compare them with the rules of any other plan that covers you or your family.**

## Introduction

### Welcome to Kaiser Permanente

Welcome to Kaiser Foundation Health Plan of Ohio. Kaiser Foundation Health Plan of Ohio is a Health Insuring Corporation. We are pleased that you have selected us as your health care provider. Please take a few minutes to review this Evidence of Coverage. If you have questions about your benefits or accessing care, please call Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**.

### About This Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the “Kaiser Permanente Deductible/Copayment” health care coverage you have through a contract between Kaiser Foundation Health Plan of Ohio and your employer or association (Group) that pays us your monthly Premium.

The information in this EOC replaces all previous EOC information. It is important that you use only the latest EOC as your reference because benefits may change over time. We may modify this EOC in the future. If your Group continues to pay monthly Premiums or accepts benefits after the changes have gone into effect, Group thereby agrees to the changes. This consent covers you and your enrolled Family Dependents.

In this EOC, Kaiser Foundation Health Plan of Ohio is sometimes referred to as “Health Plan,” “we,” “us,” or “our.” Members or Subscribers are sometimes referred to as “you.” Some capitalized terms have special meaning in this EOC; please see the “Definitions” section for terms you should know.

A “Deductible, Copayments and Out-of-Pocket Maximum” section is included in the back of this EOC. It gives you information about the limits and maximums of your coverage in addition to those mentioned in the “Benefits” section. It also tells you what amounts, if any, you must pay. Your Group may have purchased benefits in addition to those listed on the chart in the “Deductible, Copayments and Out-of-Pocket Maximum” section. Summaries of your Group’s additional benefits (if any) follow the “Deductible, Copayments and Out-of-Pocket Maximum” section.

### Member Rights and Responsibilities

We are your partner in health care. We count on your participation in treatment and your willingness to communicate with Kaiser Permanente’s health care professionals. Working with you, we’ll ensure you receive appropriate and effective health care. If you’re an adult member, you can exercise these rights yourself. If you are a minor, or if you become incapable of making decisions about your health care, these rights will be exercised by the person having legal responsibility for participating in decisions concerning your medical care.

#### *You have the right to:*

- **Receive information about Kaiser Permanente, its services**, the practitioners and providers who provide your health care, and your rights and responsibilities as a Kaiser Permanente member.
- **Be assured of privacy and confidentiality.** You have the right to be treated with respect and recognition of your dignity and need for privacy. Kaiser Permanente will not release your medical Information without your authorization, except as required or permitted by law. You have the right to review and receive copies of your medical records, unless the law restricts our ability to make them available.
- **Participate with practitioners in your health care** and receive the medical information you need to make health care decisions. We will try to make this information as understandable as possible. You have the right to have ethical issues that arise in connection with your health care reviewed. You have the right to accept or refuse a recommended treatment. Emergencies or other circumstances occasionally may limit your participation in a treatment decision. In general, however, you will not receive any medical treatment before you or your legal representative give consent. You are entitled to an interpreter if you need one.
- **Have a candid discussion of appropriate or medically necessary treatment options** for your condition, regardless of cost or benefit coverage.

## 2013 Group Plan Evidence of Coverage

• **Use customer satisfaction resources.** We welcome your questions and comments about Kaiser Permanente, our services, the practitioners and other health care professionals providing your care, and your rights and responsibilities. You have the right to voice complaints or file appeals without concern that your care will be affected. You have the right to know about the complaints, grievances, and appeals procedures. In order to assist you, the Customer Relations staff is available to answer your questions and resolve problems.

• **Make recommendations** regarding Kaiser Permanente's members' rights and responsibilities policies.

• **Express your wishes concerning future care in an advance directive.** You have the right to choose a person to make medical decisions for you if you are unable to do so. Your choices regarding your future care may be expressed in such documents as a durable power of attorney for health care or a living will. You should inform your family and practitioner of your wishes and give them any documents that describe your choices regarding future care.

• **Have impartial access to medically indicated treatment that is a covered benefit** regardless of your race, religion, gender, sexual orientation, national origin, cultural background, disability, or financial status. You have the right to access emergency health care services for conditions of sufficient severity that a prudent layperson could expect the absence of immediate medical attention to result in serious jeopardy to your health or serious impairment or dysfunction of bodily functions.

• **Have a safe, secure, clean, and accessible health care environment.**

• **Participate in physician selection.** You have the right to select a physician with an open practice as your primary care practitioner and to change your primary care practitioner at a future date. You have the right to a second opinion by a Kaiser Permanente practitioner. You have the right to consult with a non-Kaiser Permanente practitioner at your own expense.

• **Receive relevant information and education that helps ensure your safety in the course of treatment.**

• **Receive information about the outcomes of care you have received, including unanticipated outcomes.**

• **Make complaints and receive a summary of information on the appeals and grievances** other members have filed in the past.

• **Have prescriptions refilled within a reasonable period of time.**

• **Receive information about drug coverage and costs.**

*You have the responsibility to:*

• **Provide accurate and complete information about your present and past medical conditions** (to the extent possible) that the organization and its practitioners and providers need in order to provide care. You should report unexpected changes in your condition to your practitioner.

• **Follow the treatment plan to which you and your health care practitioner agree.** You should inform your practitioner if you do not clearly understand your treatment plan and what is expected of you. If you believe you cannot follow through with your treatment, you are responsible for telling your practitioner.

• **Understand your health problems and participate in developing mutually agreed-upon treatment goals,** to the degree possible.

• **Know the extent and limitations of your health care benefits.** An explanation of these is contained in your *Evidence of Coverage*.

• **Identify yourself with your member ID card.** You are responsible for your membership card, for using it only as appropriate, and for ensuring that other people do not use your card.

• **Keep scheduled appointments or cancel, in a timely manner, any appointments you are unable to keep.** You are responsible for promptly canceling any appointment that you don't need or cannot keep.

- **Provide accurate and complete information** regarding your current address, your eligibility status, the eligibility status of your dependents, and coverage or payments for health services available to you from other sources.
- **Recognize the effect of your lifestyle on your health.** Your health depends not just on care provided by Kaiser Permanente, but also on the decisions you make in your daily life.
- **Be considerate of others.** You should respect other people and their property, as well as the people and property of Kaiser Permanente.
- **Fulfill financial obligations.** You should pay on time any money you owe Kaiser Permanente.

## Eligibility and Enrollment

### Who Is Eligible

#### General

To be eligible to enroll and remain enrolled, you must meet the following requirements:

- You must meet your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements), and you must also meet the Subscriber or Dependent eligibility requirements that follow.
- You must live in our Service Area (our Service Area is described in the "Definitions" section). To find out if your Group has chosen an expanded enrollment provision, refer to the section following the Copayment chart. However, the Subscriber's or the Subscriber's Spouse's otherwise eligible children who live outside our Service Area may be eligible to enroll if they meet the dependent eligibility requirements as described in the Dependents section of this Evidence of Coverage.
- Neither you or any member of your family may enroll under this EOC if you or any dependent have ever had entitlement to receive Services through Health Plan terminated for:
  - Being disruptive, unruly, or abusive.
  - Misrepresenting membership status, presenting an invalid prescription or physician order, misusing (or letting someone else misuse) a Member ID card, or committing any other type of fraud, or misrepresentation.
  - Furnishing incorrect or incomplete information or failing to give notice of changes in family status or Medicare coverage.
- You must continue to meet your Group's eligibility requirements. You are required to notify Health Plan of any changes in eligibility. Failure to notify may result in termination.

#### Subscribers

You may be eligible to enroll as a Subscriber if you are:

- An employee of your Group who works at least the number of hours specified by your Group.
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service (IRS) considers you self-employed).
- Entitled to Subscriber coverage under your Group's eligibility requirements that we have approved.

#### Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

- Your Spouse.
- Your or your Spouse's children (including adopted children or children placed with you for adoption) who are under age 26.
- Other dependent persons (but not including foster children) who meet all of the following requirements:
  - They are under age 26 and;
  - You or your Spouse is the court-appointed guardian (or was before the person reached age 18).

#### Overage Dependents

Dependents who meet the General eligibility requirements may continue coverage beyond the limiting age at the request of the subscriber and upon payment of any applicable additional premium, if all of the following requirements are met:

- They are unmarried and under the age of 28 and:

## 2013 Group Plan Evidence of Coverage

- They are the natural child, stepchild, or adopted child of the subscriber, and;
- They are a resident of the state of Ohio or a full-time student at an accredited public or private institution of higher education and;
- They are not employed by an employer that offers any health benefit plan under which the child is eligible for coverage and;
- They are not eligible for coverage under the Medicaid or Medicare program and;
- You give us a signed Coverage Dependent Attestation form to verify that the Dependent meets all criteria specified in this section with 31 days of the child reaching the limiting age, or upon initial enrollment, and annually thereafter, if required by Health Plan. Coverage terminates when the Dependent child no longer meets all of the criteria specified in the General and Coverage Dependents sections of this EOC.

**Note:** The limiting age for Dependents and student Dependents set by your Group can be found in the Copayment chart in the back of this EOC. Your Group may have requested other Eligibility options. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to find out.

### **Student Eligibility**

In order for a Dependent child over age 19 to be eligible for membership as a student, the Subscriber must complete and send us proof affirming that the Dependent is a student as defined by your Group.

Postsecondary educational institution students who suffer a severe illness or injury that causes them to lose full-time student status will remain classified as students for eligibility purposes for up to 12 months after loss of full-time student status if, within 31 days after that loss of full-time student status, we receive written certification from the child’s treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary. Coverage for students on medical leave of absence is subject to a maximum of 12 months from the first day of the medically necessary leave of absence and shall not continue beyond the effective date of the termination of the Group Policy.

### **Continuation of Coverage**

Persons who meet the Dependent eligibility requirements except for the limiting age will remain eligible if all the following requirements are met:

- They are incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to reaching the limiting age of Group and;
- They receive from you or your Spouse substantially all of their support and maintenance (as defined by the IRS) and;
- You give us proof of their incapacity and dependency within 31 days of the child reaching the limiting age and annually thereafter, if requested by Health Plan. Coverage terminates when the Dependent child no longer meets all of the criteria specified in this section.

### **Genetic Screening and Testing Prohibition**

Renewal of this contract is not subject to genetic screening or testing or the results of genetic screening or testing.

### **Enrollment and Effective Date of Coverage**

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date. If you or any eligible Dependent is confined to a hospital, skilled nursing facility or other institution on your effective date, you must notify us immediately so that we can transfer your covered Medically Necessary care to a Plan Facility and Plan Physician. Coverage is limited to Services rendered on or after your effective date and time.

### **New Employees and Their Dependents**

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved Enrollment/Change Form to your Group within 31 days after you become eligible (you should check with your Group to see when new employees become eligible). Your membership will become effective the first of the month following the date the Enrollment/Change Form is received by Health Plan unless otherwise specified by your Group and approved by Health Plan.

### **Special Enrollment**

If you do not enroll in any coverage through your group when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

## 2013 Group Plan Evidence of Coverage

- You become eligible as described in this “Special Enrollment” section or in any of the subsequent open enrollment provisions outlined below.
- You did not enroll in any coverage through your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is not later than the first day of the month following the date your Group receives a Health Plan approved Enrollment/Change Form from the Subscriber.

### **Special Enrollment Due to Newly Acquired Dependents**

You may enroll as a Subscriber (along with any eligible Dependents) and existing Subscribers may add any or all eligible Dependents, by submitting a Health Plan-approved Enrollment/Change Form to your Group within 31 days after establishment of marriage, birth, adoption, or placement for adoption.

The membership effective date for the Dependents will be:

- For newborn children of the Subscriber or the Subscriber’s Spouse, the moment of birth. A newborn child is automatically covered for the first 31 days, subject to coordination of benefits rules, but must be enrolled within 31 days after birth and an additional Premium may be due for membership to continue.
- For newly adopted children (including children newly placed for adoption), the date of the adoption or legal placement for adoption.
- For new spouses, the date of marriage. The Subscriber must enroll his/her Spouse within 31 days following the date of marriage. This provision applies to other eligible dependents joining the Plan as a result of a new Spouse being added to the Plan.
- For all other Dependents, the first of the month following the date the Enrollment/Change Form is received by Health Plan, unless otherwise specified by your Group and approved by Health Plan.

**Note:** Children born to an eligible Dependent other than the Subscriber or the Subscriber’s Spouse are not eligible for coverage unless the Subscriber or the Subscriber’s Spouse adopts them or becomes their court appointed guardian.

### **Special Enrollment Due to Loss of Other Coverage**

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your group.
- The loss of the other coverage is due to one of the following:
  - Exhaustion of COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) coverage.
  - Termination of employer contributions for non-COBRA coverage,
  - Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, or the Subscriber’s death, termination of employment, or reduction in hours of employment.
  - The loss of eligibility for Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause.
  - Reaching a lifetime maximum on all benefits.

**Note:** If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved Enrollment/Change Form to your Group within 31 days after receipt of a notice of termination letter, except that the timeframe for submitting the Enrollment/Change Form is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an Enrollment/Change Form from the Subscriber.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date Health Plan receives the Enrollment/Change Form.

**Special Enrollment Due to Court or Administrative Order.** Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a

## 2013 Group Plan Evidence of Coverage

Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved Enrollment/Change Form.

Your Group will determine the effective date of an enrollment resulting from a court or administrative order, except that the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

**Special Enrollment Due to Reemployment after Military Service.** If you terminated your health care coverage because you were called to active duty in the military service, you may be able to be reenrolled in your Group's health Plan if required by state or federal law. Please ask your Group for more information.

**Special Enrollment Due to Eligibility for Premium Assistance under Medicaid or CHIP.** You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Health Plan-approved Enrollment/Change Form to your Group within 60 days after the Subscriber or Dependent is determined eligible for premium assistance. The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your Group receives an Enrollment/Change Form from the Subscriber.

**Note:** If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

### Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved Enrollment/Change Form to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

## How to Obtain Services

### Important Information About Our Providers

As a Member, you are selecting our medical care program to provide your health care. The Services described in this EOC are benefits ONLY if they are provided, prescribed or directed by a Plan Physician. We will not pay for Services received from non-Plan physicians or from non-Plan facilities that have not been provided, prescribed, or directed by a Plan Physician. These charges are your financial responsibility. You must receive all covered care from Plan Providers, except as described under the following headings:

- [Emergency Services](#)
- [Getting a Referral](#)

We contract with the Ohio Permanente Medical Group, Inc. (Medical Group) to provide care to our Members in the Service Area. In addition, Medical Group has contracted with selected physicians and allied professionals in the community to provide covered Services directly to Members in their private offices; these are called “Affiliated Physicians.” Collectively, we refer to Medical Group Physicians and Affiliated Physicians as “Plan Physicians.” Plan Physicians provide or arrange all of your non-emergency care. A most recent list of these Plan Physicians can be found in the Provider Directory. You may obtain a copy at any time by calling Customer Relations at one of the following numbers: (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)** or visit our website at <https://healthy.kaiserpermanente.org/health/care/consumer/locate-our-services/doctors-and-locations>.

A list of our Plan Providers is available in the Provider Directory, which you may have received when you enrolled in the Plan. In addition, Kaiser Permanente Members may receive a Provider Directory at any time through one of the following methods:

1. You can call Customer Relations to have the most recent printed copy of the Provider Directory sent to you or to verify availability of various Plan Providers. Just call us at one of the following numbers: (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**; or,
2. For the most up to date list of our Plan Providers you can visit our website at [kp.org/formsandpubs](http://kp.org/formsandpubs) to view, print, or download an electronic version of our most current printed Provider Directory.

We will notify you 30 days in advance if you are receiving Services from a Plan Physician or Plan Facility and that provider's association with us ends. We will continue to cover Services rendered by that provider until we can arrange for the transfer of your care to another Plan Physician or Plan Facility.

Kaiser Permanente is not a member of the guaranty fund. Except for any Deductibles and Copayments owed by you, the providers that contract with us to provide covered Services to you seek compensation for covered Services solely from us and not from you. In addition, in the case of our insolvency, you may be financially responsible for health care services rendered by a provider that is not under contract with us, whether or not we authorized the use of the non-contracted provider. Additionally, in the case of our insolvency or discontinuance of operations, providers and/or health care facilities shall continue to provide covered Services to you as needed to complete any Medically Necessary procedure which started prior to but is unfinished at the time of the insolvency or discontinuance of operations. If you are hospitalized at the time of the insolvency or discontinuance of operations, then providers and/or health care facilities shall continue to provide covered Services to you as needed, upon payment of any Deductibles and Copayments up to the occurrence of any one of the following: (1) the end of the 30-day period following a liquidation order; (2) the end of your period of coverage for a contractual prepayment or membership charges; (3) you obtain equivalent coverage with another health plan or insurer, or your employer obtains such coverage for you; (4) you or your employer terminates coverage under the contract; or (5) a liquidation effects a transfer of Health Plan's obligation under the contract under Ohio law. Contact Customer Relations for further information at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**.

### **Your Primary Care Physician**

Your Primary Care Physician (PCP) plays an important role in coordinating your health care needs, including hospital stays and Referrals to specialists. We encourage you to choose a PCP when you enroll. You may choose any Primary Care Plan Physician who is available to accept you. Parents may choose a pediatrician as the personal Plan Physician for their child. Every Member of your family should have his or her own PCP. If you did not select a PCP upon enrollment, we will assign you one located near your home.

When choosing your PCP, please keep in mind that your choice will determine where you will receive specialty and hospital care. Your PCP has an established relationship with a specific group of specialty care physicians and hospitals with whom he or she works. By referring only to a select group of specialists and hospitals, your PCP is better able to coordinate and oversee your medical care. If there are specific specialists or hospitals you want to be referred to, find out whether your PCP works with those specialists or hospitals. You can change your PCP at any time if you want to be referred to a specialist or hospital that does not have a relationship with your current PCP. Changing your PCP is not a guarantee that you will receive a Referral to the doctor or hospital that you request. See "Getting a Referral" below, for more information.

**Note:** If you wish to change your PCP, you must notify us first before scheduling treatment. If you do not notify us in advance that you are changing your PCP, you will be responsible for paying full charges for the care you receive from the new physician. To change your PCP, call us at (216) 524-5001 or 1-877-524-5001 (216) 398-3187 or **1-877-398-3187 – TTY for the hearing/speech impaired** or visit [kp.org/medicalstaff](http://kp.org/medicalstaff). Generally, changes to a PCP are effective the first of the month following the request for change. It is important to remember that switching to a new PCP may also change the specialty physicians and hospitals available to you.

### **Getting a Referral**

Plan Physicians offer primary medical and pediatric care, as well as specialty care in areas such as obstetrics/gynecology, general surgery, orthopedic surgery, and dermatology. **To receive covered services from a provider other than your PCP, except for covered Plan obstetrical or gynecological Services, outpatient mental health and chemical dependency Services, Emergency Services and optometry Services from a Plan optometrist, you must have a Referral and a Written Authorization for Medical Care.** To schedule an appointment or to obtain a list of contracted providers, please contact Customer Relations at (216) 621-7100 **(1-877-676-6677-TTY for the hearing/speech impaired)**. To schedule an appointment with a Medical Group provider, please call the Member Service Center at 216 524-7377 or 1-800-524-7377 **(1-877-676-6677 TTY for the hearing/speech impaired)**. However you must seek this care from a Plan Provider listed in the Provider Directory.

A Referral is a written recommendation by a Plan Physician for you to receive a covered Service from a designated referral provider. A Referral is limited to a specific Service, treatment, series of treatments, or period of time. All Referral Services must be requested and approved in advance by your Plan Physician. A Referral does not guarantee that the Services or supplies requested will be covered. The Medical Group reserves the right to review and approve each Referral through our utilization review process. We will issue a Written Authorization for Medical Care for Referrals we approve. We will not pay for any care rendered or recommended by a referral provider beyond the limits of the original Referral unless we specifically authorize the care. Please see the "Utilization Review" section in the Appendix of this EOC for more information on how we

conduct reviews. Deductibles and Copayments apply to Referral Services. A written or verbal recommendation by a Plan Physician that you obtain non-covered Services (whether Medically Necessary or not) is not considered a Referral, and the Service is **not covered**.

If your Plan Physician determines that you require covered Services not available from us, he or she will recommend to Medical Group that you be referred to a non-Plan Provider inside or outside our Service Area. **You must have a Written Authorization for Medical Care from the provider in order for us to cover the Services.** Deductibles and Copayments for Referral Services are the same as those required for Services provided by a Plan Physician.

If you require specialized care for a condition or a disease, and your Plan Physician determines that such specialty care is appropriate over a long period of time, you may receive a Referral to a specialist who has expertise in treating your condition or disease. This Referral applies only if your condition or disease is life threatening, degenerative, or disabling. However, such Services are subject to the terms of a treatment plan and the applicable covered benefits you are enrolled under at the time of the Service. The specialist will also coordinate your other health care needs. The specialist will then provide or direct your health care needs in the same manner as your Plan Physician.

**Unless otherwise specified, if you receive Services from any doctor, hospital or other health care provider without first obtaining a Referral and a Written Authorization for Medical Care from us, you will be financially responsible.** If you intend to use other health insurance coverage to pay for non-referred Services, please remember that we will not pay any residual amounts (such as deductibles or coinsurance) that are **not covered** or not paid by the other insurance plan. If you are planning to receive Services outside our Plan, or to learn more about Referrals, please contact Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**.

**Note:** Any dissatisfaction that you may have with our providers does not give you the right to self-refer outside the Plan to receive Services from non-Plan providers and expect payment or reimbursement from us. See the “Getting Assistance, Claims and Appeals Procedure, and Dispute Resolution” section for ways to express your dissatisfaction.

### **Second Opinions**

Upon request and subject to payment of any applicable Deductible and Copayments you may get a second opinion from a Plan Physician about any proposed covered Services. If the first two physicians disagree, you may request a third opinion. A Referral to a non-Plan physician for a second or third opinion will only be made if we are unable to provide a second or third opinion in-Plan. If you elect to obtain a second opinion from a non-Plan physician without a Referral, or a third opinion when the first two physicians agree, you must pay for such Services yourself.

### **Plan Facilities**

We operate several outpatient treatment facilities throughout the Service Area, which are staffed by Medical Group Physicians. These facilities are referred to as “Medical Offices.” In addition, we contract with some facilities, including Plan Hospitals, to provide specific Services for Members when provided or authorized by a Plan Physician. These facilities are referred to as “Plan Facilities.” Collectively, we refer to Medical Offices and Plan Facilities as “Plan Facilities.”

Plan Facilities are listed in the Provider Directory. You can get a current copy by calling Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)** or accessing the Provider Directory online at [kp.org/formsandpubs](http://kp.org/formsandpubs).

### **Getting the Care You Need**

Contact the office of your PCP for all of your routine or urgent care needs. For coverage information about urgent care, refer to “Urgent Care Services” in the “Benefits” section. Emergency care is covered 24 hours a day, seven days a week, anywhere in the world. If you think you have a medical emergency, call 911 or go to the nearest emergency room. For coverage information about emergency care, including emergency benefits away from home, refer to “Emergency Services” in the “Benefits” section. If you are unsure whether you are experiencing an emergency and have selected a Medical Group Physician as your PCP, call our 24-hour Care Line for assistance at (1-800-524-7377 **(1-877-398-3187 – TTY for the hearing/speech impaired)**). If your PCP office is closed, please call our 24-hour Care Line for assistance at the above number.

### **Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas**

If you visit the service area of another Region temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services, Deductibles, and Copayments described in this

EOC. The 90-day limit on visiting member care does not apply to Members who attend an accredited college or accredited vocational school.

Service areas and facilities where you may obtain visiting member care may change at any time. To receive more information about visiting member care, including facility locations in other service areas, or to request a copy of the visiting member brochure, please call Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)** or visit our website at <https://healthy.kaiserpermanente.org>.

### **Using Your Identification Card**

Each Member has a Health Plan ID card with a medical record number on it. Take your ID card with you when you go to a Plan Provider for care or have it handy when you call for advice or make an appointment. The medical record number is used to identify your medical records and membership information. You should always have the same medical record number. If we ever inadvertently issue you more than one medical record number, or if you need to replace your card, please let us know by calling Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**.

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be financially responsible for any Services we provide and claims for emergency or urgent care Services from non-Plan providers will be denied. If you let someone else use your ID card, we will keep your card and terminate your membership. Lost or stolen cards must be reported immediately to Customer Relations.

## **Benefits**

The benefits and Services your coverage provides are defined below. **Deductibles, Copayments visit limits, quantity limits, or time limits, if any, are listed in the “Deductible, Copayments and Out-of-Pocket Maximum” section or this “Benefits” section.**

Unless otherwise specified, visit or day limits are calculated on a calendar year basis. Visit limits for Services that have limits may be reduced by the number of visits incurred during the same calendar year that you are enrolled through the same employer. Any additional benefits your Group may have purchased and any Deductibles and Copayments are described on the pages immediately following the “Deductible, Copayments and Out-of-Pocket Maximum” section.

The benefits and Services described in this EOC are covered only when:

- Listed as covered Services and;
- Determined by a Plan Physician to be Medically Necessary to prevent, diagnose, or treat a medical condition. A Service is Medically Necessary only if a Plan Physician determines that it is medically appropriate for you and that its omission would adversely affect your health and;
- Provided, prescribed, or authorized by a Plan Physician and;
- Provided at a Plan Facility or Skilled Nursing Facility in the Service Area or provided by Plan Providers (unless otherwise noted) and;
- You have met any Deductible requirements described in the “Deductible, Copayments and Out-of-Pocket Maximum” section.

We will not cover Services or supplies that do not meet these criteria. Non-covered Services are your financial responsibility.

Exclusions and limitations that apply only to a particular benefit are described in this “Benefits” section. Exclusions, limitations and reductions that apply to all benefits are described in the “General Exclusions/Limitations/Reductions” section.

Your Plan Physician must obtain approval from us for certain Services for coverage. Before giving approval, we consider if the Services meet the criteria above. We call this review the pre-service review. Your Plan Physician must obtain a pre-service review for Services such as:

- Hospital admissions.
- Referrals to specialists.
- Recommendations for follow-up care.
- Skilled nursing care.
- Surgical procedures.
- Durable Medical Equipment.

For a complete list of Services requiring pre-service review, call Customer Relations at (216) 621-7100 or 1-800-686-7100

**(1-877-676-6677 – TTY for the hearing/speech impaired).** If Services are not precertified they will not be covered. If Services are approved you will receive a Written Authorization for Medical Care. See “Getting a Referral” in the “How to Obtain Services” section.

This “Benefits” section includes both basic and supplemental health care services. Basic Health Care Services are defined as the following Services when Medically Necessary:

- Plan Physician Services (except those associated with Supplemental Health Care Services).
- Inpatient Hospital Services.
- Outpatient Medical Services.
- Emergency Services.
- Urgent Care Services.
- Diagnostic laboratory Services and diagnostic and therapeutic radiological Services.
- Diagnostic and treatment Services, other than prescription drug Services, for biologically based mental illnesses.
- Preventive health care services including but not limited to voluntary family planning Services, infertility Services, periodic physical examinations, prenatal obstetrical care, and well-child care.
- Routine Patient Care for patients enrolled in an Eligible Cancer Clinical Trial as described under the “Definitions” section of this EOC.

Supplemental Health Care Services which may be covered under this EOC include:

- Dental care.
- Vision care and optometry Services.
- Podiatric care or foot care Services.
- Mental Health Services, excluding diagnostic and treatment Services for biologically based mental illnesses.
- Medical or psychological treatment and Referral Services for alcohol and drug abuse or addiction.
- Home health Services.
- Outpatient prescription drug Services.
- Nursing Services.
- Services of a dietician.
- Physical therapy and chiropractic Services.

### **Outpatient Care**

We cover the following outpatient care in our Plan Facilities for preventive medicine, diagnosis, education, and treatment including professional medical Services of physicians and other health care professionals:

- Primary care office visits for internal medicine, family practice, and pediatrics.
- Specialty care office visits, including consultation and second opinions with Plan Physicians in departments other than those listed under “Primary care office visits” above.
- Allergy consultations, testing, and treatment (immunotherapy).
- Minor surgical procedures performed in the office.
- Anesthesia and pain management Services.
- Respiratory therapy.
- Chemotherapy.
- Radiation therapy.
- Blood and blood products (whole blood, packed red cells, cryoprecipitates, platelets, plasma, and fresh frozen plasma) and their administration.
- Medical social Services.
- Outpatient surgery (Services performed in a hospital or ambulatory surgical center).
- House calls by a Plan Physician when care can best be provided in your home, as determined by a Plan Physician.
- Obstetrical Department prenatal and postnatal visits.
- Drugs that require administration or observation by medical personnel.

**Note:** See “Preventive Exams and Services” for more information on preventive Services covered under this Plan.

### **Hospital Inpatient Care**

All hospital admissions, except for Emergency Services as described in “Emergency Services” in this “Benefits” section, must be arranged and approved by your Plan Physician prior to your admission.

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

## 2013 Group Plan Evidence of Coverage

- Room and board, including a private room, if Medically Necessary.
- Specialized care and critical care units.
- General nursing care and special duty nursing care, if Medically Necessary.
- Special diet.
- Operating and recovery room.
- Obstetrical care and delivery (including cesarean section).
- Plan Physician and surgeon Services and supplies, including consultation and treatment by specialists.
- Anesthesia.
- Medical supplies and equipment, including oxygen.
- Blood and blood products (whole blood, packed red cells, cryoprecipitates, platelets, plasma, and fresh frozen plasma), and their administration.
- Respiratory therapy.
- Physical, occupational, and speech therapy for the purpose of restoring previously existing function.
- Medical social Services and discharge planning.
- Drugs that require administration or observation by medical personnel.

**Note:** Women who undergo a covered mastectomy may have this procedure performed, at their option, on an inpatient basis. They may receive inpatient Services for up to 48 hours or longer, if Medically Necessary, after the procedure.

**Note:** In the case of a normal delivery, the mother, at her option, may receive up to 48 hours of inpatient Services for her and normal routine nursery care for the newborn. In the case of a cesarean delivery, the mother, at her option, may receive up to 96 hours of inpatient Services for her, and normal routine nursery care for the newborn. Should the mother elect to leave the hospital prior to the expiration of the applicable number of hours of inpatient care, follow-up care will be provided for the mother and newborn within 72 hours of discharge according to state law. This follow-up visit may occur in a medical setting or the home and applicable Deductibles and Copayments will apply.

**Note:** Separate Deductibles and Copayments for inpatient hospital stays, if any, apply to the mother and the newborn.

**Note:** Health Plan will pay for health care services limited to delivery and up to 48 hours of normal routine nursery care for a newborn of a Dependent who is not otherwise eligible for coverage.

### **Other Benefits**

The following types of Services and supplies are covered only as described under these headings in this “Benefits” section:

- Ambulance.
- Chemical Dependency Services.
- Dialysis.
- Drugs and Supplies.
- Durable Medical Equipment (DME), External Prosthetics, and Orthotics.
- Emergency Services.
- Family Planning.
- Hearing.
- Home Health.
- Hospice.
- Infertility Services.
- Laboratory, X-ray, and Other Diagnostic Services.
- Mental Health Services.
- Outpatient Physical, Occupational, and Speech Therapy, Cardiac and Multidisciplinary Rehabilitation.
- Preventive Exams and Services.
- Prosthetic Devices (Internally Implanted).
- Reconstructive Surgery.
- Skilled Nursing Facility Services.
- Transplant Services.
- Urgent Care Services.
- Vision Services.

### **Ambulance**

We cover the Services and supplies of a licensed ambulance (including licensed air ambulance), only if, in the judgment of a Plan Physician, your condition requires the use of medical Services and supplies that only a licensed ambulance can provide and the use of other means of transportation would endanger your health. We will not cover ambulance Services in any other circumstances, even if no other transportation is available. We cover ambulance Services only inside our Service Area, except as covered under “Emergency Services” in this “Benefits” section.

Exclusion:

Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and other types of transportation (other than a licensed ambulance) is not covered, even if it is the only way to travel to a facility.

**Chemical Dependency Services**

**Outpatient Detoxification**

We cover Services for the medical management of withdrawal symptoms.

**Outpatient Therapy**

We cover individual or group therapy sessions for the treatment of chemical dependency. This includes visits for the purpose of monitoring drug therapy.

**Inpatient (Detoxification Only)**

All hospital admissions, except for Emergency Services as described in “Emergency Services” in this “Benefits” section, must be arranged and approved by your Plan Physician prior to your admission.

**In a general hospital:**

We cover an unlimited number of days and admissions for medical management of withdrawal symptoms in a general Plan Hospital when a Plan Physician deems this setting Medically Necessary.

**In a specialized facility:**

If prescribed by a Plan Physician, medical management of withdrawal symptoms in a specialized chemical dependency treatment facility or program is covered in a facility that we designate.

Exclusions:

- Inpatient residential rehabilitation is not covered.
- Methadone maintenance is not covered.

*Your Group may have requested other Chemical Dependency benefits. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to find out.*

**Dialysis**

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

- The Services are provided inside our Service Area.
- You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis.
- The facility is certified by Medicare.
- A Plan Physician provides a written Referral for care at the facility.

We also cover equipment, training, and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

**Drugs and Supplies**

We use a drug formulary. The medications included in the Kaiser Permanente Formulary are chosen by a group of Kaiser Permanente physicians, pharmacists, and nurses known as the Pharmacy and Therapeutics Committee. This Committee meets regularly to evaluate and choose those medications that are effective, safe, and useful in caring for our Members. You may obtain a copy of the Member Drug Formulary at any Kaiser Permanente pharmacy located in a Kaiser Permanente facility, by calling Customer Relations at (216) 621-7100 or 1-800-686-7100

**(1-877-676-6677 – TTY for the hearing/speech impaired)**, by visiting our website at [kp.org/formsandpubs](http://kp.org/formsandpubs) or by writing to:

Pharmacy Administration  
Kaiser Permanente  
5420 Lancaster Drive  
Brooklyn Heights, Ohio 44131

Drugs are covered when a prescription is required by law and when they are listed in the Health Plan Drug Formulary. This includes coverage for off-label formulary drug usage in the treatment of a particular condition for a drug that is approved by the Food and Drug Administration (FDA) and is recognized as safe and effective for that

condition in published, authoritative medical, scientific, or pharmaceutical literature. Unless nonformulary drug coverage is available through another benefit offered through Kaiser Permanente, nonformulary drugs will be covered in the same manner as formulary drugs when (i) the Plan Physician documents in the Member's medical record and certifies that the formulary alternatives have been ineffective in the treatment of the Member's disease or condition or (ii) that the formulary alternatives cause or is reasonably expected by the Plan Physician to cause harmful or adverse reactions and (iii) the use conforms to guidelines and criteria reviewed and approved by the Kaiser Foundation Health Plan of Ohio's Pharmacy and Therapeutics Committee.

### **Administered Drugs**

The following drugs and supplies are covered during an approved inpatient stay in a Plan Hospital or Skilled Nursing Facility. They are also covered if they require administration or observation by medical personnel and are administered to you in a Plan Facility, emergency facility, urgent care facility, or during home visits and physician house calls.

The following drugs are covered:

- All prescribed drugs, except those used for the evaluation or treatment of involuntary infertility.
- Injectables.
- Radioactive materials used for therapeutic purposes.
- Vaccines and immunizations approved for use by the FDA and which are medically indicated and consistent with accepted medical practice. See "Preventive Exams and Services" for more information on immunizations.
- Allergy testing and treatment materials.

Drugs for the further evaluation or treatment of involuntary infertility are described under the "Infertility" section.

### Exclusions:

- Unless an exception is approved by Health Plan, drugs not approved by the FDA are not covered.
- If a Service is not covered under this EOC, any drugs or supplies needed in connection with that Service are not covered.
- Internally implanted and injectable contraceptives are not covered.

### **Drugs Purchased by Members**

Drugs purchased by Members are not covered unless your Group purchased additional Prescription Drug benefits.

To find out if your Group purchased additional Prescription Drug benefits, refer to the "Additional Information or Other Benefits Purchased by Your Group" section immediately following the benefit chart at the end of this EOC.

### **Durable Medical Equipment (DME), External Prosthetics, and Orthotics**

DME is Medically Necessary equipment appropriate for use in your home and able to withstand repeated use. It is equipment that would not be of use to you in the absence of illness or injury and it must be consistent with Medicare guidelines. In order to have coverage, you must meet our Health Plan criteria for use of any equipment. Coverage is limited to the standard item of equipment that adequately meets your medical needs. We will decide whether to rent or purchase the covered equipment for your use. You will have to pay for non-covered equipment. When the item continues to be Medically Necessary, coverage includes repair and replacement of the standard item in cases of loss, irreparable damage, wear or replacement required because of a change in the Member's condition. We may require you to return the equipment to us, or pay us the fair market price of the equipment, when it is no longer prescribed. We cover the following DME items when provided by Plan Providers and prescribed by Plan Physicians in accord with Health Plan guidelines:

- Apnea monitors for infants for a period of up to six months of use.
- Oxygen dispensing equipment and oxygen, including pulse oximetry for infants.
- Bilirubin lights for home photo therapy for infants.
- Traction equipment.
- Negative pressure wound dressings.

A prosthetic device is a device that replaces all or part of a body organ or that replaces all or part of the function of a permanently inoperative or malfunctioning body organ. We cover external breast prostheses following a covered mastectomy. Coverage is limited to one prosthesis per Member every 12 months (or two per Member every 12

## 2013 Group Plan Evidence of Coverage

months in cases of covered bilateral mastectomy). We also cover up to four mastectomy bras every 12 months, unless more are Medically Necessary due to changes in your condition. We cover compression sleeves and gloves used in treatment of physical complications of the mastectomy, including lymphedema.

Orthotics are rigid or semi-rigid external devices that are used for the purpose of supporting a weak or deformed body member or for restricting or eliminating motion in a diseased or injured part of the body. Orthotic devices are not covered.

### Exclusions:

- Convenience and luxury items and features are not covered.
- Replacements necessitated by misuse are not covered.
- All other external prosthetics not listed above are not covered.
- All orthotic devices are not covered.
- All other DME items not listed above are not covered.

**Note:** Although certain devices are not covered, Services your Plan Physician may provide which are necessary to determine your need for a prosthetic or orthotic device are covered.

***Your Group may have requested other DME, External Prosthetics and Orthotics benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.***

### Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world, as long as the Services would have been covered under the "Benefits" section (subject to the "General Exclusions/Limitations/Reductions" section) if you had received them from Plan Providers.

Emergency Services are covered when you present to an emergency facility with an emergency medical condition or when a person authorized by us refers you to an emergency facility. If you are unsure whether you are experiencing an emergency call our 24-hour Care Line for assistance at 1-800-524-7377 (**1-877-398-3187 – TTY for the hearing/speech impaired.**) Refer to the Provider Directory for the emergency number of your physician's office (if your PCP's office is closed, please call our 24-hour Care Line for assistance at the above number). To better coordinate your emergency care, if you are inside the Service Area, you should go to a Plan Facility, if possible. If you are unsure if you are experiencing a medical emergency, call our 24 hour Care line at 1- 800-524-7377 or **1-877-398-3187 – TTY for the hearing/ speech impaired.** Our staff including Registered Nurses and Physicians are available 24/7 to meet your health care needs.

If you are admitted to a non-Plan hospital, you, a member of your family or the admitting physician must notify us by calling 1-866-433-1333 either before you are admitted, or if that is not possible, or as soon as medically possible after you are admitted. We will decide whether to make arrangements for necessary continued hospitalization or transfer you to a designated hospital. If you do not notify us or refuse to be transferred, we will not cover any Services you receive after transfer would have been possible.

- **Inside Our Service Area.** If you are inside our Service Area, we will cover In-Plan or Out-of-Plan Emergency Services as defined above.
- **Outside Our Service Area.** If you are injured or become unexpectedly ill while you are outside of our Service Area, we will cover Out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility. This includes Out-of-Plan Emergency Services for conditions which arise unexpectedly.
- **Follow-up Care to Emergency Services Outside the Service Area.** We will pay up to \$500 per Member per calendar year for follow-up care received outside of our Service Area if the treatment is:
  - Otherwise covered under this Plan; and
  - Received after the initial Emergency Services were received or is received in a setting other than the setting where the Emergency Services were received; and

## 2013 Group Plan Evidence of Coverage

- Performed on an outpatient basis outside our Service Area pursuant to a covered out-of-area Emergency Service.

Payment will be limited to Emergency Services required before your medical condition permits your travel or transfer to a Plan Facility. When approved by Health Plan or by a Plan Physician in this Service Area or in another Kaiser Foundation Health Plan or allied plan service area, we will cover ambulance Services or other transportation medically required to move you to a designated facility for continuing or follow-up care. Continuing or follow-up care from non-Plan providers is not covered unless we decide not to transfer you to a Plan Facility except as specified above. We will reduce our payments for Out-of-Plan Emergency Services by the following amounts:

- Applicable Deductibles and Copayments.
- Any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid. If payment under the other insurance or program is not made within a reasonable period of time, we will pay for covered Out-of-Plan Emergency Services if you:
- Agree to cooperate with us in obtaining payment. Health Plan has reimbursement rights limited to the amount we have paid for covered Services.
- Allow us to obtain any relevant information from the other insurance or program.
- Provide us with any information and assistance we need to obtain payment from the other insurance or program.

**Note:** The procedure for receiving reimbursement for Out-of-Plan Emergency Services is described in the “Getting Assistance, Claims and Appeals Procedure, and Dispute Resolution” section.

**Note:** Once the Deductible, if any, has been satisfied, the Emergency Services Copayment, if any, is waived when you are admitted as an inpatient to the hospital directly from the Emergency Department, emergency facility or observation unit. Transfer to, or an overnight stay in an observation unit or observation bed of a hospital for any duration of time does not qualify as an inpatient admission to a hospital and your Emergency Services Copayment, if any, will not be waived.

### **Family Planning**

We cover family planning counseling, voluntary terminations of pregnancy, including pre and post termination counseling, birth control counseling, tubal ligations, and vasectomies. See the section titled: “Laboratory, X-ray, and Other Diagnostic Services” for information regarding those Services.

#### Limitations and Exclusions:

- Elective medical (chemically induced) or surgical abortions are limited to those as a result of rape, incest, or when the life of the mother is threatened.
- Elective medical (chemically induced) or surgical abortions are not covered.
- Contraceptive devices are not covered.

***Your Group may have requested other Family Planning benefits. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to find out.***

### **Hearing**

We cover medical Services necessary for the diagnosis and treatment of illness or injury to the ear. This includes hearing tests to determine the need for hearing correction.

#### Exclusions:

- Tests to determine an appropriate hearing aid are not covered.
- Hearing aids or tests to determine their efficacy are not covered.

***Your Group may have requested other Hearing benefits. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to find out.***

### **Home Health**

We cover skilled, part-time, or intermittent Medically Necessary home health Services within the Service Area when you are confined to your home. The Services are covered only if a Plan Physician determines that it is feasible to

## 2013 Group Plan Evidence of Coverage

maintain effective supervision and control of your care in your home. These Services must be prescribed or directed by a Plan Physician, as recommended by our Home Care Agency. Covered Services and items include skilled nursing care, home health aide Services, medical social Services, intravenous fluids and drugs, additives and nutrients administered therewith, and I.V. equipment and infusion pumps, physical, occupational, and speech therapy. Physical, occupational, and speech therapy are may be provided in the home at no charge.

Unless mentioned above, the following types of Services and supplies are covered as part of home health Services and supplies only as described under these headings in this “Benefits” section:

- Drugs and Supplies.
- Durable Medical Equipment (DME), External Prosthetics, and Orthotics.

### Exclusions:

- Custodial care is not covered.
- Full time nursing care in the home is not covered.
- Homemaker services and supplies, including meals delivered to your home, are not covered.
- Home health care that a Plan Physician determines may be appropriately provided for you in a Plan Facility, hospital, or a Skilled Nursing Facility is not covered.

### Hospice

We cover hospice care only within our Service Area and if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six months or less, you can choose home-based hospice care instead of traditional Services and supplies otherwise provided for your illness. If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this EOC. You may continue to receive Plan benefits for conditions other than the terminal illness. You may change your decision to receive hospice care at any time.

We cover the following Services and supplies when approved by a Plan Physician and provided by an approved hospice agency.

- Plan Physician and nursing care.
- Counseling and bereavement Services.
- Physical, occupational, speech, or respiratory therapy.
- Medical social Services.
- Home health aide and homemaker Services.
- Medical supplies and appliances.
- Palliative drugs, in accord with our drug formulary guidelines.
- Short-term inpatient care, limited to respite care and care for pain control, and acute and chronic symptom management.

### Infertility Services

We cover the following Services:

- Inpatient and outpatient Services after diagnosis, for the further evaluation to determine the cause of infertility, and Services for the treatment of involuntary infertility. This includes necessary laboratory and radiology Services and drugs administered by medical personnel for the further evaluation or treatment of involuntary infertility. A diagnosis of infertility is made when a couple has not been able to conceive after 12 months of unprotected intercourse (six months if the woman is over 35 years of age).
- Artificial insemination for the treatment of involuntary infertility.

### Exclusions: (See “General Exclusions/Limitations/Reductions” section also).

- Donor semen or eggs, and Services related to their procurement and storage, are not covered.
- Services to reverse voluntary, surgically induced infertility (for example, because of a vasectomy or tubal ligation) are not covered.
- Services related to a surrogacy arrangement, including but not limited to conception, pregnancy or delivery are not covered as a means to correct a Member’s infertility. A surrogacy arrangement is one in which a woman agrees to become pregnant and surrender the baby to another person or persons who intend to raise the child.
- Drugs are not covered under this benefit. See “Drugs and Supplies” to find out if drugs for the treatment of infertility are covered.

Refer to “Surrogacy Arrangements” in the Reduction section for further information.

***Your Group may have requested other benefits for Infertility Services. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to find out.***

### **Laboratory, X-ray, and Other Diagnostic Services**

We cover the following laboratory, radiology, and diagnostic Services:

- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available.
- X-rays and diagnostic imaging.
- Special procedures such as electrocardiograms and electroencephalograms.

**Note:** See “Preventive Exams and Services” for additional information on preventive Services that may be covered under this Plan. Different Deductibles and Copayments may apply.

#### **Limitation:**

Laboratory, X-ray, and other diagnostic Services related to infertility are listed under “Infertility Services.”

#### **Exclusion:**

Testing provided for family members who are not Members is not covered.

### **Mental Health Services**

#### **Biologically Based Mental Illnesses**

“Biologically Based Mental Illnesses” means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. Diagnostic and treatment Services for these illnesses are covered as a Basic Health Care Service, such as:

#### **Inpatient**

Inpatient Services for the diagnosis and treatment of Biologically Based Mental Illnesses are covered including the Services of Plan Physicians and other mental health professionals when performed, prescribed, or directed by a Plan Physician. Such Services may include individual therapy, group therapy, shock therapy, drug therapy, and psychiatric nursing care.

#### **Outpatient Therapy**

Outpatient Services for the diagnosis and treatment of Biologically Based Mental Illnesses are covered including Services provided by Plan Providers such as psychiatrists, psychologists, psychiatric social workers, and clinical nurse specialists, such as:

- Individual and group therapy visits for diagnostic evaluation and psychiatric treatment.
- Visits for the purpose of monitoring drug therapy.
- Treatment in a partial hospitalization program as an alternative to inpatient care.

#### **Other Mental Health Illnesses**

Other Mental Health Illnesses are mental health illnesses that are not Biologically Based Mental Illnesses. We cover evaluation, crisis intervention, and treatment for Other Mental Health Illnesses.

#### **Inpatient**

We cover psychiatric hospitalization in a Hospital for the diagnosis and treatment of Other Mental Health Illnesses including the Services of Plan Physicians and other mental health professionals when performed, prescribed, or directed by a Plan Physician. Such Services include individual therapy, group therapy, shock therapy, drug therapy, and psychiatric nursing care. See the “Deductible, Copayments and Out-of-Pocket Maximum” section for day limits, Deductibles and Copayments.

#### **Outpatient Therapy**

Outpatient mental health care services for the diagnosis and treatment of Other Mental Health Illnesses are provided by Plan Providers such as psychiatrists, psychologists, psychiatric social workers, and clinical nurse specialists. The following Services are covered:

- Individual therapy visits for diagnostic evaluation and psychiatric treatment. See the “Deductible, Copayments and Out-of-Pocket Maximum” section for visit limits, Deductibles, and Copayments.
- Group therapy visits. Two group therapy visits count as one individual therapy visit toward visit maximums.
- Visits for the purpose of monitoring drug therapy.

#### **Inpatient Alternative Services**

If a Plan Physician prescribes it, we cover treatment in a partial hospitalization program as an alternative to inpatient care. You may receive two sessions (visits) in a partial hospitalization program in place of one day of inpatient hospital care. We also cover home psychiatric care if a Plan Physician prescribes it instead of inpatient hospitalization.

*Your Group may have requested other Mental Health benefits. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to find out.*

### **Outpatient Physical, Occupational, and Speech Therapy, Cardiac and Multidisciplinary Rehabilitation**

#### **Outpatient Physical, Occupational, and Speech Therapy**

Prescribed outpatient physical therapy, occupational therapy, and speech therapy to restore previously existing function is covered when provided in Plan Facilities.

#### **Cardiac Rehabilitation**

Prescribed outpatient Cardiac Rehabilitation to restore previously existing function is covered when provided in Plan Facilities.

#### **Multidisciplinary Rehabilitation**

Multidisciplinary rehabilitation Services are provided to restore previously existing physical function when a Plan Physician determines that your condition may be significantly improved within two months. You are covered for up to two consecutive months of treatment per calendar year for care that is received in an approved organized inpatient multidisciplinary program or facility.

#### **Limitations:**

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Physical, speech, and occupational therapy, cardiac and multidisciplinary rehabilitation are limited to the restoration of previously existing physical functions which have been lost due to illness or injury when a Plan Physician determines that your condition may be significantly improved within a specific period of time or a specific number of visits per calendar year. Visit limits and/or time limits, if any, are listed in the “Deductible, Copayments and Out-of-Pocket Maximum” section
- Massage therapy is not covered except when part of a physical therapy treatment plan, ordered by a Plan Physician and provided by a physical therapist.

#### **Exclusions:**

- Long-term physical rehabilitation Services are not covered.
- Cognitive rehabilitation therapy Services are not covered.
- Comprehensive outpatient rehabilitation facility Services are not covered.
- Therapy primarily indicated for vocational training or re-training purposes, including sports physical therapy, is not covered.

*Your Group may have requested other Outpatient Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation benefits. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to find out.*

### **Preventive Exams and Services**

We cover a variety of preventive care Services, which are Services to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury, or condition. These preventive care Services are subject to all coverage requirements described in this “Benefits” section and all provisions in the “General Exclusions/

## 2013 Group Plan Evidence of Coverage

Limitations/Reductions” section. Refer to the Copayment chart to find out what Copayments if any, may apply. Services include:

- Well-child care exam for children under 24 months.
- Preventive physical exams, for members 24 months and older, performed by a PCP or specialist, including well-women exams.
- Flexible Sigmoidoscopy, Screening Colonoscopy or Fecal Immunohistochemical Test (FIT) when performed as a preventive health screening procedure.
- Preventive health screening tests:
  - Fecal occult blood,
  - Chlamydia screening,
  - Cholesterol screening,
  - Diabetes screening, fasting blood glucose test,
  - Human Papillomavirus (HPV) Detection screening,
  - PAP smear (cytologic screening to detect cervical cancer),
  - Prostate specific antigen (PSA) test,
  - Screening Mammograms (a physician’s order or Referral is not required for screening mammograms at Plan facilities).
  - Immunizations (except travel immunizations).

Additionally, if your Group has purchased Preventive benefits as mandated by the Patient Protection and Affordable Care Act (PPACA), the preventive care Services described on our “Preventive Care Services Covered With no Copayments” list are covered at no charge.

If your Group purchased preventive benefits as mandated by the Patient Protection and Affordable Care Act (PPACA), the benefit chart at the back of this Evidence of Coverage will include a section called “Preventive Care Services as mandated by the Patient Protection and Affordable Care Act”. Services include but are not limited to:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Routine prenatal care office visits
- Rental of hospital-grade electric breast pump for up to twelve months of use; limited to one pump per birth.

Eligible Services under the Patient Protection and Affordable Care Act (PPACA) have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. To view this list, please visit [www.healthcare.gov/center/regulations/prevention.html](http://www.healthcare.gov/center/regulations/prevention.html).

Preventive Services mandated under the Patient Protection and Affordable Care Act (PPACA) may change according to federal guidelines and will be in effect as of January 1<sup>st</sup>, when this policy renews. You will be notified, at least sixty (60) days in advance, if any item or Service is removed from the list of Covered Services.

Please call Customer Relations at (216) 621-7100 or 1-800-686-7100 (**1-877-676-6677 – TTY for the hearing/speech impaired**), or visit our website at [kp.org](http://kp.org) if you have any questions, need to determine whether a service is eligible for coverage as a preventive Service, or to request a copy of our “Preventive Care Services Covered With No Copayments” list.

The following provisions apply to all Services described in this Preventive Exams and Services section:

**Should you receive other covered preventive Services or covered non-preventive Services for an existing illness, injury, or condition during a preventive care examination, you may be charged the applicable Copayments and/or Deductibles for those Services.**

### **Prosthetic Devices (Internally Implanted)**

A prosthetic device is a device that replaces all or part of a body organ or that replaces all or part of the function of a permanently inoperative or malfunctioning body organ. We cover internally implanted prosthetic devices that replace the function of all or part of an internal body organ, including internally implanted breast prostheses following a covered mastectomy. The devices must be approved for general use by the FDA.

### **Reconstructive Surgery**

We cover inpatient and outpatient Services that:

- Will result in significant improvement in physical function, including correction of congenital defect, disease or anomaly when there will be significant improvement in physical function; or,
- Treat congenital hemangioma, known as port wine stain, on the face of Members age 18 or younger; or,
- Will correct significant disfigurement resulting from an injury or covered surgery; or,
- Will result in the reconstruction of the breast on which a mastectomy was performed as well as surgery and reconstruction of the other breast to produce a symmetrical appearance. Treatment of physical complications at all stages of a mastectomy, including lymphedemas is covered.

**Note:** Outpatient surgical procedures performed in an ambulatory surgical care center for reconstructive surgery are covered under “Outpatient Care.”

### **Skilled Nursing Facility Services**

We cover skilled inpatient Services and supplies at an approved Skilled Nursing Facility when prescribed by a Plan Physician and approved by Medical Group. The skilled inpatient Services and supplies must be Medically Necessary, customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services and supplies:

- Plan Physician and nursing Services.
- Room and board.
- Medical social Services.
- Prescribed drugs as described under “Drugs and Supplies.”
- Respiratory therapy.
- Short term physical, occupational, and speech therapy.
- Medical equipment ordinarily furnished by the Skilled Nursing Facility.

***Your Group may have requested other benefits for Skilled Nursing Facility Services. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to find out.***

### **Transplant Services**

We cover transplants of organs, tissues (including stem cell rescue), or bone marrow that are not experimental or investigational in nature if:

- Medical Group has determined that you meet certain medical criteria for patients needing transplants; and
- Medical Group provides a written Referral to an approved transplant facility. The facility may be located outside the Service Area. Transplants are covered only at a facility approved by Medical Group, even if another facility within the Service Area could perform the transplant.

Covered Services include:

- Inpatient Services as described under “Hospital Inpatient Care.”
- Outpatient Services as described under “Outpatient Care.”
- Reasonable transportation and lodging expenses outside of the Service Area when arranged in advance by us. Coverage will include the Member, one parent or guardian if the Member is a minor or one other person if the Member is an adult.
- Reasonable medical and hospital expenses of an organ/tissue donor which are directly related to a covered transplant for a Member are covered only if such expenses are incurred for Services within the United States or Canada. Coverage of expenses for these Services is subject to Donor Service Guidelines. To obtain a copy, contact Customer Relations at (216) 621-7100 or 1-800-686-7100 (**1-877-676-6677 – TTY for the hearing/speech impaired**). Limitations and exclusions apply to donor Services.

Limitations and Exclusions:

- We do not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.
- Organ/tissue transplants which are experimental or investigational are not covered.
- Non-human and artificial organs and their implantation are not covered.

**Urgent Care Services**

Urgent care Services are Services for unexpected illness or injury that require prompt medical attention but do not meet the definition of Emergency Services.

**In Our Service Area**

Urgent care Services are covered and may be provided in your doctor's office or a Plan urgent care facility. Contact your PCP's office 24 hours a day if you need urgent care. You can also call our 24 hour Care line at 1-800-524-7377 or **(1-877-398-3187 – TTY)** for the hearing/ speech impaired with any questions or concerns about your urgent medical issue. Our staff including Registered Nurses and Physicians are available 24/7 to meet your health care needs. You may be directed to obtain urgent care Services at a Plan urgent care facility. A list of Plan urgent care facilities can be found in the Provider Directory or on our website at [kp.org/facilities](http://kp.org/facilities). If Plan urgent care Services are received in your doctor's office, you will pay the office visit Copayment. However, if urgent care Services are received at a Plan urgent care facility, you will pay the Plan urgent care facility Copayment, which may be different. See the Copayment chart for the Copayment that applies to Services provided in a doctor's office or Plan urgent care facility.

**Note:** Additional diagnostic and treatment Services may be subject to deductible and coinsurance when applicable.

Exclusion:

Except as noted below, urgent care Services from non-Plan providers are not covered.

**Outside of Our Service Area**

Urgent care Services are also covered when you are temporarily away from the Service Area. Urgent care Services are covered when they are Medically Necessary and it is not reasonable given the circumstances to obtain the Service through us.

**Vision Services**

We cover routine eye exams (eye refractions) without a Referral from Plan Optometrists designated by Health Plan to determine the need for vision correction. However, Services, including routine eye exams, performed by a Plan Ophthalmologist require a Referral. Any Deductibles and Copayments that you must pay for these Services are listed in the "Deductible, Copayments, and Out-of-Pocket Maximum" section in the back of this EOC.

Exclusions

- Corrective lenses, eyeglasses, frames, and contact lenses (including the fitting of contact lenses) are not covered.
- All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures) are not covered.
- Orthoptic (eye training) therapy is not covered.
- Low vision aids and Services are not covered.

*Your Group may have requested other Vision benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.*

## **General Exclusions/Limitations/Reductions**

**Exclusions**

With reference to all exclusions mentioned in this EOC, the word "Service" means any treatment, therapeutic, or diagnostic procedure, drug, facility, equipment, device, or supply, or use of any of them. When a Service is excluded, all Services that are necessary for the excluded Service and that would otherwise be covered under this Agreement are also excluded except for Services required because of complications. Also see the "Benefits" section for exclusions and limitations listed under specific benefits. The following are **not covered** unless otherwise provided by your Group as described in the "Additional Information or Other Benefits Requested by Your Group" section following the "Deductible, Copayments, and Out-of-Pocket Maximum" section:

## 2013 Group Plan Evidence of Coverage

1. Services that are not Medically Necessary - for example, paternity testing, etc., are not covered.
2. Except for Emergency Services and Referral Services, Services and supplies not provided, arranged, or authorized by a Plan Physician are not covered.
3. Alternative medical Services including acupuncture, naturopathy, and massage therapy are not covered. However, massage therapy may be covered when part of a physical therapy treatment plan, ordered by a Plan Physician, and provided by a physical therapist.
4. Air casts are not covered.
5. Artificial Conception: Services, other than artificial insemination, for conception by artificial means, including, but not limited to, procedures related to pre-implantation genetic diagnosis prior to in vitro fertilization, in vitro fertilization, ovum transplants, gamete intrafallopian transfer, zygote intrafallopian transfer, all Services related to non-covered methods, drugs, donor semen, donor eggs, and Services related to their procurement and storage including cryopreservation are not covered. This exclusion applies to fertile and infertile individuals or couples.
6. Specialized behavioral modification programs to maximize a person's ability to control pain, obesity, eating disorders or other chronic conditions are not covered. However, biofeedback is covered when administered by the Mental Health Department as part of a prescribed pain management program or as part of a treatment regimen for other physical symptoms that are not responsive to usual medical treatment
7. Blood and blood products not listed as covered in the "Benefits" section are not covered. The collection, transportation, storage, and processing of donor directed blood or blood products, are not covered. Procurement and storage of cord blood for a possible future need or for a yet to be determined Member recipient, is not covered.
8. Chiropractic Services are not covered.
9. Comfort or convenience items such as, but not limited to, telephone or television service during an inpatient stay are not covered.
10. Cosmetic Services are not covered. Plastic surgery or any other Services that are indicated primarily to change or maintain your appearance are not covered except for Services covered under "Reconstructive Surgery" described in the "Benefits" section.
11. Non-Plan provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers are not covered unless care would be covered as an Emergency Service.
12. Custodial or intermediate care is not covered. Custodial care includes assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide care, do not require medical licenses or certificates or the presence of a supervising nurse. Other non-covered custodial or intermediate care Services include activities such as walking, bathing, getting in and out of bed, dressing, feeding, toileting, and taking medications.
13. Dental Services, including dental x-rays are not covered. Dental Services are those Services rendered in connection with the care, treatment, filling or removal or replacement of teeth or structures directly supporting the teeth. Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process. Dental Services following accidental injury to teeth; dental appliances and orthodontia are not covered. Dental Services associated with medical treatment, such as surgery and dental Services associated with radiation treatment are not covered. Dental Services for cosmetic purposes or correction of malocclusion and dental treatment of temporomandibular joint (TMJ) dysfunction syndrome are not covered. Also excluded is hospitalization for extraction of teeth or any other dental procedure, except when a Plan Physician determines there is a need for hospitalization for reasons unrelated to the dental procedure. In this case, we will cover the hospitalization, but will not cover the cost of the professional dental Services.
14. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices not specifically listed as covered in the "Benefits" section are not covered.
15. Experimental or investigational Services are not covered except for Routine Patient Care associated with cancer clinical trials as described under the "Definitions" section. A Service or supply is experimental or investigational if we, in consultation with Medical Group, determine that:
  - a) Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question; or,
  - b) It cannot be legally marketed in the United States without the approval of the FDA and such approval has not been granted; or,
  - c) It requires government approval that has not been obtained when the Service or supply is to be provided; or,
  - d) It is the subject of a current new drug or new device application on file with the FDA; or,
  - e) It is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Service; or,
  - f) It is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or,
  - g) It is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of Services; or,

## 2013 Group Plan Evidence of Coverage

- h) It is provided pursuant to informed consent documents that describe the Service as experimental or investigational, or in other terms that indicate that the Service is being evaluated for its safety, toxicity, or efficacy; or,
  - i) The prevailing opinion among experts is that the Service should be substantially confined to research settings or further research is necessary to determine the safety, toxicity, or efficacy of the Service; or,
  - j) There is no prevailing opinion among experts as expressed in the published authoritative medical, scientific, or pharmaceutical literature describing that the Service is safe and effective.
16. Routine Patient Care associated with an “Eligible Cancer Clinical Trial” must be prescribed, provided, or authorized by a Plan Physician. “Routine Patient Care” means all health care services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial. Routine Patient Care does not include:
- i) A Service, item, or drug that is the subject of the cancer clinical trial; or,
  - ii) A Service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient; or,
  - iii) An investigational or experimental drug or device that has not been approved for market by the FDA; or,
  - iv) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial; or,
  - v) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or,
  - vi) A Service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.
17. Hypnotherapy and hypnotic anesthesia are not covered.
18. Services for military service-connected illness, injury, or conditions when care from the Department of Veteran Affairs is reasonably available are not covered.
19. Routine foot care Services that are not Medically Necessary are not covered.
20. All Services related to sexual reassignment are not covered.
21. Services that are the financial responsibility of an employer or Services that a government agency is required by law to provide are not covered.
22. Services are not covered for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as “Financial Benefit”), is provided or payable under any workers’ compensation or employer’s liability law. We will provide Services in Plan-operated facilities even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Eligible Charges for any such Services from the following sources:
- a) Any source providing a Financial Benefit or from whom a Financial Benefit is due; or,
  - b) You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers’ compensation or employer’s liability law.
23. Travel and lodging expenses are not covered, except that in some situations, if a Plan Physician refers you to a non-Plan provider outside our Service Area as described under “Getting a Referral” in the “How to Obtain Services” section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines.
24. Services to patients who are seeking Services for other than therapeutic purposes or who are not responsive to therapeutic management are not covered.
25. Testing for ability, aptitude, intelligence, or interest is not covered.
26. Care, as a condition of probation, parole, or any other third party or court order is not covered, unless a Plan Physician determines such Services to be Medically Necessary and appropriate.
27. Inpatient Residential rehabilitation such as in a psychiatric nursing home or Skilled Nursing Facility is not covered. This includes specialized behavioral programs in a residential facility.
28. Long term rehabilitation services are not covered.
29. Recreational therapy, music therapy, diversional therapy and play therapy are not covered. Physical examinations or other Services: (a) required for obtaining or maintaining employment, or participation in employee programs; (b) required for insurance or licensing; or (c) on court order or required for parole or probation, are not covered unless a Plan Physician determines the Services to be Medically Necessary.
30. Ongoing medical treatment for conditions of which you are aware and should have known would require treatment while outside the Service Area, other than conditions defined as Emergency Medical Conditions, is not covered.
31. Sales Tax.

### **Limitations**

We will use our best efforts to provide or arrange for our Members’ health care needs in the event of unusual circumstances that delay or render impractical the provision of Services and supplies under this EOC, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities,

and labor disputes not involving Health Plan or Medical Group. However, Health Plan, Medical Group, and Medical Group Providers will not have any liability for any delay or failure in providing covered Services and supplies. In the case of a labor dispute involving Health Plan or Medical Group, we may provide alternative care until the dispute is resolved.

## **Reductions**

### **Coordination of Benefits (COB)**

The Coordination of Benefits (“COB”) provision applies when a Covered Person has health care coverage under more than one Plan.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

### **Definitions:**

A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and nongroup insurance contracts, health insuring corporations (“HIC”) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
- Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; and supplemental coverage where the following applies: the policy covers a specified disease or a limited plan of coverage; the policy is specifically designed, advertised, represented, and sold as a supplement to other basic sickness and accident insurance coverage; and the entire premium for the policy is paid by the insured, their family, or their guardian. The Plan does not include school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies/ Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage outlined in the two paragraphs listed above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

**This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply to COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

**The order of benefit determination** rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

**Allowable expense** is a health care expense, including deductibles, coinsurance and Copayments that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

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

## 2013 Group Plan Evidence of Coverage

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
- The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admission, and preferred provider arrangements.

**Closed panel** plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

**Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

### **Order of Benefit Determination Rules**

When a Covered Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

- A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary except as stated in the following paragraph.
- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

- (1) Non-Dependent or Dependent. The Plan that covers the Covered Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the Covered Person as a dependent is the Secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Covered Person as a dependent, and primary to the Plan covering the Covered Person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

## 2013 Group Plan Evidence of Coverage

- (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
- (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
  - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
  - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
- (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
- (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
- (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
- The Plan covering the Custodial parent;
  - The Plan covering the spouse of the Custodial parent;
  - The Plan covering the non-custodial parent; and then
  - The Plan covering the spouse of the non-custodial parent.
- (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active employee or retired or laid-off employee. The Plan that covers a covered person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same covered person as a retired or laid-off employee is the Secondary plan. The same would hold true if a covered person is a dependent of an active employee and that same covered person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the above rule (1) can determine the order of benefits.
- (4) COBRA or state continuation coverage. If a covered person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the covered person as an employee, member, subscriber or retiree or covering the covered person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the above rule (1) can determine the order of benefits.
- (5) Longer or shorter length of coverage. The Plan that covered the covered person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the covered person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

### **Effect On The Benefits Of This Plan**

When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

### **Right To Receive And Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The claims administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the Covered Person claiming benefits. The claims administrator need not tell, or get the consent of, any person to do this. Each Covered Person claiming benefits under This plan must give the claims administrator any facts it needs to apply those rules and determine benefits payable.

### **Facility Of Payment**

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, the claims administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. The claims administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

### **Right Of Recovery**

If the amount of the payments made by the claims administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

### **Coordination Disputes**

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Customer Relations at (216) 621-7100 or 1-800-686-7100 (**1-877-676-6677** – TTY for the hearing/speech impaired) or mail a letter to: Customer Relations, Kaiser Foundation Health Plan of Ohio, P.O. Box 5309, Cleveland, Ohio 44101.

If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

### **Injuries or Illnesses Alleged To Be Caused By Third Parties**

Where a Member has benefits paid by Health Plan for the treatment of sickness or injury caused by a third party, there are conditional payments that must be reimbursed by the Member if the Member receives or has a right to recover any compensation, damages, or other payment as a result of the sickness or injury from any party that may be liable and person, organization, or insurer, including a Member's own insurer and any uninsured and/or underinsured motorist insurance. Health Plan may subrogate to the Member's rights of recovery. Health Plan has reimbursement and subrogation rights equal to the non-Member rate of medical benefits paid for covered Services provided to the Member. The Health Plan shall have the right to proceed in the name of the member with or without his or her consent. Health Plan's reimbursement and subrogation rights are a first priority lien claim on the proceeds of any judgment or settlement the Member obtains against a third party or other organization or person. Such proceeds must be applied to pay Health Plan's lien claim before any other claims, including claims by the Member for damages (with the exception of claims by the Member pursuant to the property damage provisions of any insurance policy). This means the Member must reimburse Health Plan, in an amount not to exceed the total recovery, even when the Member's settlement or judgment is for less than the Member's total damages and must be paid without any reductions for attorneys' fees or costs. The Health Plan specifically opts out of the Made Whole rule and the Made Whole federal common law. The Health Plan's right of subrogation will apply even if the member has not been made whole for the loss. The Health Plan specifically opts out of the Common Fund Doctrine. If a Member fails to reimburse the Health Plan from any third party recovery, then the Health Plan may withhold future benefits equal to that amount.

### **Surrogacy Arrangements**

A surrogacy arrangement is one in which you agree to become pregnant and surrender the baby to another person or persons who intend to raise the child. If you receive covered Services through us related to conception, pregnancy, or delivery in connection with a surrogacy arrangement (Surrogacy Health Services) you must pay us the lesser of the compensation you are entitled to receive under the surrogacy arrangement or the Eligible Charges for the covered Surrogacy Health Services rendered.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement. To secure our rights, we will also have a lien on those payments to the extent of health care services provided by or paid for by Health Plan. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph. Within 30 days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to:

Patient Accounting  
Kaiser Foundation Health Plan of Ohio  
P.O. Box 5388  
Cleveland, Ohio 44101

You must complete and send us all consents, releases, authorizations, assignments, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this “Surrogacy Arrangements” section and to satisfy those rights. You must not take any action prejudicial to our rights. If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

## **Getting Assistance, Claims and Appeals Procedure, and Dispute Resolution**

### **Getting Assistance**

We want you to be satisfied with your health care. If you have questions about your Health Plan benefits or need assistance, call Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**. Representatives are available to assist you Monday – Friday, 8:00 a.m. to 8:00 p.m.

Customer Relations can answer questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace an ID card. These representatives can also help you if you need to file a claim or to initiate a grievance for an unresolved problem or initiate an appeal for denial of payment or Services.

### **Language Assistance**

We strive to provide services in a way that embraces all members, including those with limited English language ability or reading skills, diverse cultural and ethnic backgrounds, and any physical or mental disabilities. We can provide information in alternate formats, including large print, and we also offer language assistance for members who need translation or interpreter services. If you need language services, please contact Customer Relations at (216) 621-7100 or 1-800-686-7100 **(216) 635-4444 –TTY or 1-877-676-6677 –TTY for the hearing/speech impaired**. Representatives are available to assist you Monday –Thursday, 8:15 a.m. to 5:00 p.m. and on Friday, 9:00 a.m. to 5:00 p.m.

### **Claims and Appeals Procedure**

Health Plan will review Claims and Appeals, and we may use medical experts to help us review them.

The following terms have the following meanings when used in this “Claims and Appeals Procedures” section:

- A **Claim** is a request for us to:

## 2013 Group Plan Evidence of Coverage

- provide or pay for a Service that you have not received (pre-service Claim),
- continue to provide or pay for a Service that you are currently receiving (concurrent care Claim), or
- pay for a Service that you have already received (post-service Claim).
- An **Adverse Benefit Determination** is our decision to do any of the following:
  - Deny, reduce or terminate a requested health care service or payment, in whole or in part,
  - terminate your membership retroactively except as the result of non-payment of premiums or contributions towards the cost of coverage (also known as rescission), or
  - not issue health insurance coverage to an applicant in the non-employer group market
- An **Appeal** is a request for us to review our initial Adverse Benefit Determination.
- A **Final Adverse Benefit Determination** is our decision to uphold our previous Adverse Benefit Determination when you Appeal.

If you miss a deadline for making a Claim or Appeal, we may decline to review it.

### **Language and Translation Assistance**

If we send you an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then your notice of Adverse Benefit Determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language.

You may request language assistance with your Claim and/or Appeal by calling Customer Relations at (216) 621-7100 or toll-free 1-800-686-7100 or (216) 635-4444 or toll free **(1-877-676-6677-TTY for the hearing/speech impaired)**.

SPANISH (Español): Para obtener asistencia en Español, llame al. (216) 621-7100 or toll free 1-800-686-7100.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (216) 621-7100 or toll free 1-800-686-7100.

CHINESE (中文): 如果需要中文的帮助,请拨打这个号码 (216) 621-7100 or toll free 1-800-686-7100.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne (216) 621-7100 or toll free 1-800-686-7100.

If we send you an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then you may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request translation of the notice by calling Customer Relations at (216) 621-7100 - toll-free 1-800-686-7100 OR (216) 635-4444 - toll free **(1-877-676-6677-TTY for the hearing/speech impaired)**.

### **Appointing a Representative**

If you would like someone to act on your behalf regarding your Claim or Appeal, you may appoint an authorized representative. You must make this appointment in writing. Please send your representative's name, address and telephone contact information to:

Kaiser Permanente  
Appeals Unit  
P. O. Box 93764  
Cleveland, Ohio 44101-5764

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

**Help with Your Claim and/or Appeal**

You may contact The Ohio Department of Insurance’s Consumer Services Department at:

Consumer Services  
Ohio Department of Insurance  
50 W. Town Street  
Third Floor – Suite 300  
Columbus, Ohio 43215  
1-800-686-1526  
614-644-2673  
614-644-3744 (fax)  
614-644-3745 (TDD)

**Reviewing Information Regarding Your Claim**

If you want to review the information that we have collected regarding your Claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your Claim. To make a request, you should contact Customer Relations at (216) 621-7100 - toll-free 1-800-686-7100 OR (216) 635-4444 - toll free **(1-877-676-6677-TTY for the hearing/speech impaired)**.

**Providing Additional Information Regarding Your Claim**

When you Appeal, you may send us any additional information including comments, documents, and additional medical records that you believe supports your Claim (“supporting information”). If we asked for additional information and you did not provide it before we made our initial decision about your Claim, then you may still send us the additional information so that we may include it as part of our review of your Appeal. Please send all additional information to:

Kaiser Permanente Appeals Unit  
P. O. Box 93764  
Cleveland, Ohio 44101-5764

When you Appeal, you may give testimony in writing or by telephone. Please send your written testimony to:

Kaiser Permanente Appeals Unit  
P. O. Box 93764  
Cleveland, Ohio 44101-5764

To arrange to give testimony by telephone, you should contact:

Kaiser Permanente Appeals Unit  
216 635-4664 or toll free 1-888-479-5333  
**1-888-479-5371 – TTY for the hearing/speech impaired.**

We will add the information that you provide through testimony or other means to your Claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your Claim.

**Sharing Additional Information That We Collect**

We will send you any additional information that we collect in the course of your Appeal. If we believe that your Appeal of our initial Adverse Benefit Determination will be denied, then before we issue our Final Adverse Benefit Determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our final decision, that decision will be based on the information already in your Claim file.

## **Internal Claims and Appeals Procedures**

There are several types of Claims, and each has a different procedure described below for sending your Claim and Appeal to us as described in this Internal Claims and Appeals Procedures section:

- Pre-service Claims (urgent and non-urgent)
- Concurrent care Claims (urgent and non-urgent)
- Post-service Claims

In addition, there is a separate Appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission).

If we fail to make a determination regarding your initial pre-service, concurrent care or post-service Claim(s) within the timeframe required for our decision, then you may request a review (Appeal) without waiting for our initial Claim decision by following the procedure for filing an Appeal. However, if we ask for additional information about your Claim and you, your provider or your health care facility fails to provide us with the information that we request to make a decision regarding your initial Claim, then we will notify you in writing of the reason for our delay and you will not be permitted to Appeal before we make our decision about your initial pre-service, concurrent care, or post service Claim(s).

### **Pre-Service Claims and Appeals**

Pre-service Claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized or precertified in order to be a covered benefit may be the basis for our denial of your pre-service Claim or a post-service Claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-service Claim or Appeal will become a post-service Claim or Appeal with respect to those Services. If you have any general questions about pre-service Claims or Appeals, please call Customer Relations at (216) 621-7100 - toll-free 1-800-686-7100 OR (216) 635-4444 toll free **(1-877-676-6677-TTY for the hearing /speech impaired)**.

Here are the procedures for filing a pre-service Claim, a non-urgent pre-service Appeal, and an urgent pre-service Appeal.

#### **PRE-SERVICE CLAIM**

- Tell Health Plan in writing that you want to make a Claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your Claim. You must either mail your Claim to us at Customer Relations, Kaiser Foundation Health Plan of Ohio, P. O. Box 5309, Cleveland, Ohio 44101 or fax your Claim to us at (216) 635-4673.
- If you want us to consider your pre-service Claim on an urgent basis, your request should tell us that. We will always treat your request as urgent if your attending health care provider tells us your Claim is urgent; otherwise, we will decide whether your claim is urgent or non-urgent if we determine that your claim is not urgent, we will treat your Claim as non-urgent. Generally, a Claim is urgent only if using the procedure for non-urgent Claims (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. Your attending provider may also tell us that your Claim involves urgent care.

We will review your non-urgent Claim and, if we have all the information we need, we will make a decision within 2 business days after obtaining all necessary information. We will notify you and your provider of an Adverse Benefit Determination by telephone or facsimile within 3 business days of making our decision and we will confirm in writing that telephone or fax notification within one business day. If we tell you we need more information, we will ask that the additional information be submitted prior to the end of the 3 business day period, so that we may make a timely decision. If we do not receive the requested information, then we will make our decision based on the information that we have.

- We will send written notice of our decision to you and, if applicable to your provider.
- If your pre-service Claim was considered on an urgent basis, we will notify you of our decision orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your Claim. Within 24 hours after we receive your Claim, we may ask you for more information. We will notify you of our

## 2013 Group Plan Evidence of Coverage

decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within 3 days after that.

- If we deny your Claim (if we do not agree to provide or pay for all the Services you requested), our Adverse Benefit Determination notice will tell you why we denied your Claim and how you can Appeal.

- **NON-URGENT PRE-SERVICE APPEAL**

- Within 180 days after you receive our Adverse Benefit Determination notice, you must tell us in writing that you want to Appeal our denial of your pre-service Claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) any supporting information. Your request and the supporting information constitute your Appeal. You must either mail your Appeal to:

Kaiser Permanente Appeals Unit  
P. O. Box 93764  
Cleveland, Ohio 44101-5764

or, fax your Appeal to (216) 635-4673.

- We will review your Appeal and send you a written decision within 30 days after we receive your Appeal.
- If we deny your Appeal, our Adverse Benefit Determination notice will tell you why we denied your Appeal and will include information regarding any further process, including external review that may be available to you.

- **URGENT PRE-SERVICE APPEAL**

- Tell us that you want to urgently Appeal our Adverse Benefit Determination regarding your pre-service Claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our Adverse Benefit Determination, and (5) all supporting information. Your request and the supporting information constitute your Appeal. You must send your Appeal to:

Kaiser Permanente Appeals Unit  
P. O. Box 93764  
Cleveland, Ohio 44101-5764

or, fax your Appeal to (216) 635-4673.

- When you send your Appeal, you may also request simultaneous external review of our initial Adverse Benefit Determination. If you want simultaneous external review, your Appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service Appeal qualifies as urgent. If you do not request simultaneous external review in your Appeal, then you may be able to request external review after we make our decision regarding your Appeal (see “External Review” in this “Claims and Appeals Procedures” section), if our internal Appeal decision is not in your favor.
- We will decide whether your Appeal is urgent or non-urgent unless your attending health care provider tells us your Appeal is urgent. If we determine that your appeal is not urgent, we will treat your Appeal as non-urgent. Generally, an Appeal is urgent only if using the procedure for non-urgent Claims or Appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. Your attending provider may also tell us that your Claim involves urgent care.
- We will review your urgent Appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your Appeal. If we notify you of our decision orally, we will send you a written confirmation within 3 days after that. If your Appeal is not urgent, then we will notify you of our decision no later than 30 days from the date we receive your Appeal.

- If we deny your Appeal, our Adverse Benefit Determination notice will tell you why we denied your Appeal and will include information regarding any further process, including external review that may be available to you.

### **Concurrent Care Claims and Appeals**

Concurrent care Claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, either because you want your current course of covered treatment to be extended after it is supposed to end or you want to continue your course of treatment when we determine that your treatment should end early. If you have any general questions about concurrent care Claims or Appeals, please call Customer Relations at (216) 621-7100 - toll free 1-800-686-7100 OR (216) 635-4444 - toll free **(1-877-676-6677-TTY for the hearing/speech impaired)**.

If we either (a) deny your request to extend your current authorized ongoing care (your concurrent care Claim) or (b) inform you that authorized care that you are currently receiving is going to end early, and you Appeal our Adverse Benefit Determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your Appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your Appeal and your Appeal does not result in our approval of your concurrent care Claim, then you will have to pay for the Services that we decide are not covered.

Here are the procedures for filing a concurrent care Claim, a non-urgent concurrent care Appeal, and an urgent concurrent care Appeal:

#### **• CONCURRENT CARE CLAIM**

- Tell us in writing that you want to make a concurrent care Claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your Claim. You must either mail your Claim to us at Appeals Unit, Kaiser Foundation Health Plan of Ohio, P. O. Box 93764, Cleveland, Ohio 44101-5764 or fax your Claim to us at (216) 635-4673.
- If you want us to consider your Claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent Claim on an urgent basis. We will decide whether your Claim is urgent or non-urgent unless your attending health care provider tells us your Claim is urgent. If we determine that your Claim is not urgent, we will treat your Claim as non-urgent. Generally, a Claim is urgent only if using the procedure for non-urgent Claims (a) could seriously jeopardize your life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. Your attending provider may also tell us that your Claim involves urgent care.
- We will review your Claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your Claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your Claim, we will make our decision no later than (a) 15 days after we receive your Claim or (b) within one business day of receiving all information that we need to make our decision. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 day decision period ends. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe we gave you for sending the additional information.
- We will send written notice of our decision to you and, if applicable to your provider.
- If we consider your concurrent Claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your Claim. If we notify you of our decision orally, we will send you written confirmation within 3 days after receiving your Claim.

## 2013 Group Plan Evidence of Coverage

- If we deny your Claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our Adverse Benefit Determination notice will tell you why we denied your Claim and how you can Appeal.

- **NON-URGENT CONCURRENT CARE APPEAL**

- Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to Appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting information. Your request and all supporting information constitute your Appeal. You must send your Appeal to:

Kaiser Permanente Appeals Unit  
P. O. Box 93764  
Cleveland, Ohio 44101-5764

or, fax your Appeal to (216) 635-4673.

- We will review your Appeal and send you a written decision as soon as possible if your care has not ended but not later than 30 days after we receive your Appeal.
- If we deny your Appeal, our Adverse Benefit Determination decision will tell you why we denied your Appeal and will include information about any further process, including external review that may be available to you.

- **URGENT CONCURRENT CARE APPEAL**

- Tell us that you want to urgently Appeal our adverse benefit determination regarding your urgent concurrent Claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting information. Your request and the supporting information constitute your appeal. You must send your Appeal to:

Kaiser Permanente Appeals Unit  
P. O. Box 93764  
Cleveland, Ohio 44101-5764

or fax your Appeal to (216) 635-4673.

- When you send your Appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your Appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care Claim qualifies as urgent. If you do not request simultaneous external review in your Appeal, then you may be able to request external review after we make our decision regarding your Appeal (see “External Review” in this “Claims and Appeals Procedures” section).
- We will decide whether your Appeal is urgent or non-urgent unless your attending health care provider tells us your Appeal is urgent. If we determine that your Appeal is not urgent, we will treat your Appeal as non-urgent. Generally, an Appeal is urgent only if using the procedure for non-urgent Appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. Your attending provider may also tell us that your Claim involves urgent care.
- We will review your urgent Appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within 3 days after that. If your appeal is not urgent, then we will notify you of our decision no later than 30 days from the date we receive your Appeal.
- If we deny your Appeal, our Adverse Benefit Determination notice will tell you why we denied your Appeal and will include information about any further process, including external review that may be available to you.

### **Post-Service Claims and Appeals**

Post-service Claims are requests that we for pay for Services you already received. If you receive services from a Participating Provider, the Plan Provider should submit their requests for payment directly to us unless you owe an amount for a non-covered service or cost sharing (such as a copayment or deductible amount). If you receive services from any other licensed provider, you may need to file the claim yourself and will be reimbursed in accordance to the plan. If you have any general questions about post-service Claims or Appeals, please call Customer Relations at (216) 621-7100 - toll-free 1-800-686-7100 OR (216) 635-4444 - toll free **(1-877-676-6677-TTY for the hearing/speech impaired)**.

Here are the procedures for filing a post-service Claim and a post-service Appeal:

- **POST-SERVICE CLAIM**

- Within one year after the date you received or paid for the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill and any supporting information. Your letter and the related information constitute your Claim. You must either mail your Claim to Kaiser Permanente, P.O. Box 5316, Cleveland, Ohio 44101-9774 or, fax your Claim to (216) 635-4673.
- We will not accept or pay for Claims received from you after one year from the date of Services.
- We will review your Claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your Claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision. If we delay our decision we will notify you within 30 days after we receive your Claim. We will tell you why we are delaying our decision and when you can expect the decision to be made. If we tell you we need more information, we will ask you for the information before the end of the initial 30 day decision period ends, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.
- If we deny your Claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your Claim and how you can Appeal.

- **POST-SERVICE APPEAL**

- Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to Appeal our denial of your post-service Claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our Adverse Benefit Determination, and (5) include all supporting information. Your request and the supporting information constitute your Appeal. You must either mail you Appeal to:

Kaiser Permanente Appeals Unit  
P. O. Box 93764  
Cleveland, Ohio 44101-5764

or, fax your Appeal to (216) 635-4673.

- We will review your Appeal and send you a written decision within 30 days after we receive your Appeal.
- If we deny your Appeal, our Adverse Benefit Determination will tell you why we denied your Appeal and will include information regarding any further process, including external review that may be available to you.

**Appeals of retroactive membership termination (rescission).** We may terminate your membership retroactively (see Rescission of Membership in the Who Is Eligible section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or Appeals, please call Customer Relations at (216) 621-7100 or 1-800-686-7100 OR (216) 635-4444 - toll free **(1-877-676-6677-TTY for the hearing/speech impaired).**

Here is the procedure for filing an Appeal of a retroactive membership termination:

- **Appeal of retroactive membership termination**

- Within 180 days after you receive our Adverse Benefit Determination that your membership will be terminated retroactively, you must tell us in writing that you want to Appeal our termination of your coverage. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting information. Your request and the supporting information constitute your Appeal. You must either mail you Appeal to Appeals Unit, Kaiser Foundation Health Plan of Ohio, P. O. Box 93764, Cleveland, Ohio 44101 – 5764 or fax your Claim to us at (216) 635-4673.
- We will review your Appeal and send you a written decision within 30 days after we receive your Appeal.
- If we deny your Appeal, our adverse benefit determination notice will tell you why we denied your Appeal and will include information regarding any further process, including external review that may be available to you.

### **External Review**

If you are dissatisfied with our Final Adverse Benefit Determination, you have the right to request an external review. You have the right to request an external review of our decision by an independent review organization (IRO) if our decision involves medical judgment or medical information including one based on our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered service, or our determination that the requested care or service is experimental or investigational. If our final adverse decision does not involve medical judgment, or medical information, then your Claim is eligible for external review by the Superintendent of Insurance. You may also request external review by the Superintendent when the IRO upholds our Adverse Benefit Determination that your emergency medical services did not meet the prudent layperson definition of emergency. Regardless of who performs the external review, you will not be responsible for the cost of the external review.

#### **External Review By An IRO**

Here is the procedure for filing a request for external review by an IRO:

- Send your written request for external review within 180 days of the date of our Adverse Benefit Determination of your Appeal to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P. O. Box 93764, Cleveland, Ohio 44101 - 5764 or fax your Claim to us at (216) 635-4673.
- You must also include a written release of your medical records so that the IRO will have the necessary information to conduct an external review.
- If your request for external review involves a service that is denied based on our conclusion that such service is experimental or investigational and such service is not specifically listed as an excluded service in the Exclusions section, then with your request for external review, you must provide written certification from your physician that one of the following applies: (1) standard health care services have not been effective in improving your condition; (2) standard health care services are not medically appropriate for you; or, (3) there is no available covered service that would be more beneficial than the service requested.

- **EXPEDITED EXTERNAL REVIEW**

You may request an expedited external review in writing or orally or electronically within 180 days of the date of our Final Adverse Benefit Determination of your Appeal provided, however, if you make your request orally or electronically, you must submit written confirmation of your request to us no later than 5 days after your initial request. For expedited external review, your request must include a written certification from your treating physician:

## 2013 Group Plan Evidence of Coverage

- that you have a medical condition for which the timeframe for completion of a non-expedited review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; OR
- that if experimental or investigational services are the subject of your Claim and Appeal, the requested health care service would be significantly less effective if not promptly started.

You may also request expedited review when our Final Adverse Benefit Determination concerns an admission, availability or care, continued stay or health care service for which you have received emergency services but you have not yet been discharged from a facility.

An expedited external review will not be provided for post-service Claims.

- **SIMULTANEOUS EXPEDITED EXTERNAL REVIEW**

You may request expedited external review at the same time as your expedited internal Appeal of an Adverse Benefit Determination that is not a final adverse determination. You may make this request in writing, orally or electronically provided, however, that if you make your request orally or electronically, you must submit written confirmation of your request to us no later than 5 days after your initial request. For simultaneous expedited external review, your treating physician must certify in writing:

- that you have a medical condition for which the time frame for completion of an expedited review of an internal Appeal involving an Adverse Benefit Determination would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, OR
- that the recommended or request health care service would be significantly less effective if not promptly initiated when your Claim involves experimental or investigational services (this certification is only applicable to Claims involving services that are subject to the exclusion for experimental or investigational services).

Simultaneous expedited external review will not be provided for post-service Claims.

- **REVIEW OF YOUR REQUEST FOR EXTERNAL REVIEW**

After we receive your request for review by an IRO, we will review it for completeness. If your request is complete, we will initiate an external review immediately for expedited reviews and within five days after the receipt of your request for all other reviews and will notify you in writing of the name and contact information of the IRO assigned by the Superintendent of Insurance. Alternatively, we will send you written notice if your request for review is incomplete, and we will tell you what information is missing. Or, we may deny your request for external review by an IRO and our written notice will tell you the reason for the denial and how to Appeal the denial to the Superintendent of Insurance.

- **IRO REVIEW OF YOUR CLAIM**

You may submit, within ten business days after your receipt of our notice of the IRO's assignment, to the IRO additional information to be considered during the external review. The IRO may, but is not required to, accept and consider additional information submitted after the end of this ten business day period. The IRO will forward any and all information to us that you send it, and we may reconsider our Adverse Benefit Determination. If we decide to reverse our Adverse Benefit Determination, then we will notify you, the IRO and the Superintendent within one business day of making that decision and upon receipt of that notification, the external review will terminate.

- In its review of our Adverse Benefit Determination, the IRO will not be bound by any of our decisions or conclusions. It will provide written notice of its decision to either uphold or reverse, in whole or in part, our Adverse Benefit Determination within 30 days of receipt of your request for a non-expedited external review or within 72 hours of receipt of your expedited external review request. If you receive oral notice of the IRO's decision regarding your expedited external review, then the IRO will send written confirmation of its decision within 48 hours of your oral notice.
- Upon receipt of the IRO's decision to reverse our Adverse Benefit Determination, we must either provide or pay for, as applicable, the covered service(s) immediately in accordance with all of the terms and conditions set forth in this EOC.

**External Review By The Superintendent**

Here is the procedure for filing a request for external review by the Superintendent when you do not qualify for review by an IRO (the Adverse Benefit Determination is based on a contractual issue that does not involve medical judgment or medical information) or an IRO has upheld our Adverse Benefit Determination that your emergency medical services do not meet the prudent layperson definition:

- Send your written request for external review within 180 days of the date of our Adverse Benefit Determination of your Appeal to us: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P. O. Box 93764, Cleveland, Ohio 44101 – 5764 or fax your request to us at (216) 635-4673.
- We will submit a request for external review to the Superintendent.
- The Superintendent will review your request to determine that you have exhausted our internal Appeals procedures and that external review will not require making a decision requiring medical judgment or medical information. If medical judgment or medical information is required to make the external review decision, then the Superintendent will notify us, and we will initiate an external review by an IRO.
- We will notify you that your request is complete and will notify you in writing of the contact information for the Superintendent of Insurance. You may submit, within ten business days after your receipt of our notice of the Superintendent's acceptance of your request, to the Superintendent additional information to be considered during the Superintendent's review.
- The Superintendent will determine whether the health care service is a covered service under the terms of this EOC. If the Superintendent determines that the health care service is a covered service, we shall provide or pay for, as applicable, the service in accordance with the terms and conditions of this EOC. If the Superintendent determines that the health care service is not a covered service, then we will not cover the service.

The external review decision of the IRO or the Superintendent will be binding on you and us except to the extent that either has other remedies available under applicable law. You may not file a subsequent request for external review involving the same Adverse Benefit Determination for which you have already received an external review decision under this "External Review" section except in the event that new medical or scientific evidence is submitted to us.

**Except when external review is permitted to occur simultaneously with your urgent pre-service Appeal or urgent concurrent care Appeal, you must exhaust our internal Claims and Appeals procedure for your Claim before you may request external review unless:**

- we agree to waive the exhaustion requirement;
- we fail to provide you a written decision regarding your internal Appeal within the required timeframe;
- we fail to meet all requirements of the internal Appeal process unless our failure is *de minimis*; does not cause or is not likely to cause prejudice or harm to you; was for good cause or beyond our control; and occurred in the context of ongoing good faith exchange of information between Kaiser Permanente health plan and you; and is not reflective of a pattern or practice of non-compliance.

Our internal Claims and Appeals procedure shall be considered exhausted if you have requested an internal Appeal and you have not received a decision from us in the timeframe that is applicable to the type of Claim for which you requested our review (as further described in this "Claims and Appeals" section) or we fail to adhere to all requirements regarding the internal Appeals process.

If we deny a request for external review based on your assertion that we have failed to comply with applicable requirements, then you may request a written explanation from us. We shall provide you with the explanation within 10 days including a specific description of our reasons, if any, for asserting that our delay should not cause the internal Appeals process to be considered exhausted. You may then request review by the Superintendent of our explanation, and if the Superintendent agrees with us by affirming our decision, then you may, within 10 days of receiving notice of the Superintendent's decision, resubmit and pursue the internal Appeals procedure. Your time for requesting an internal Appeal shall begin to run upon receipt of the notice from the Superintendent.

## 2013 Group Plan Evidence of Coverage

To contact the Superintendent of the Ohio Department of Insurance:

Ohio Department of Insurance  
50 W. Town Street  
Third Floor – Suite 300  
Columbus, Ohio 43215  
1-800-686-1526  
614-644-2673  
614-644-3744 (fax)  
614-644-3745 (TDD)

### **Additional Review**

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal Claims and Appeals procedures and external review. If you are enrolled through a plan that 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.

### **Dispute Resolution**

We want you to be satisfied with our Services, our Facilities, and our Physicians. Customer Relations receives Complaints about our medical Services or administrative procedures. If you are dissatisfied for any reason, please let us know by either calling Customer Relations at (216) 621-7100 or 1-800-686-7100 (**1-877-676-6677 – TTY for the hearing/speech impaired**) or submitting your written Complaints or grievances to the attention of:

Customer Relations  
Kaiser Foundation Health Plan of Ohio  
P.O. Box 5309  
Cleveland, Ohio 44101

As with an appeal, you may choose someone to represent you in the grievance process. An authorized representative may be any person you authorize in writing to act on your behalf.

All Complaints and grievances are reviewed by an objective third party, up to and including the President of Kaiser Foundation Health Plan of Ohio or the President and Medical Director of the Ohio Permanente Medical Group. Customer Relations will acknowledge and respond to formal written grievances in writing within 30 days. You will be notified if additional time is required.

## **Termination of Membership**

This “Termination of Membership” section describes how your membership may end and explains how you may be able to maintain Health Plan coverage without a break in coverage if your membership under this EOC ends.

Your Group is required to inform the Subscriber of the date your coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents’ memberships end at the same time the Subscriber’s membership ends. You will be financially responsible for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided for inpatient confinement in a hospital.

Members who are hospitalized on the date of termination may continue coverage until the earliest occurrence of any of the following: 1) discharge from the hospital; 2) determination by the Member’s attending physician that inpatient care is no longer Medically Necessary; 3) reaching the limits of contractual benefits; 4) effective date of any new coverage.

### **Termination Due to Loss of Eligibility**

If you meet the eligibility requirements described under “Who Is Eligible” in the “Eligibility and Enrollment” section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership terminates on the last day of that month unless your Group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your Group’s benefits administrator to confirm your termination date.

### **Termination of Group Agreement**

If your Group’s Agreement with us terminates for any reason, your membership ends on the same date.

### **Termination for Cause**

We may terminate the memberships of the Subscriber and all Dependents or the offending Dependent by sending written notice to the Subscriber at least 15 days before the termination if anyone in the Family Unit:

- Is disruptive, unruly, or abusive to the extent that the ability of Health Plan or a Plan Provider to provide Services to you, or to other Members, is seriously impaired.

### **Termination for Fraud or Intentional Misrepresentation**

We may rescind the Subscriber’s membership and the memberships of all Dependents (or the offending Dependent) after it becomes effective (completely cancel membership so that no coverage ever existed) if we determine you or anyone seeking coverage on your behalf does any of the following:

- Knowingly (1) misrepresents membership status; (2) presents an invalid or altered prescription or physician order; (3) misuses (or lets someone else misuse) a Member ID card; or (4) commits any other type of fraud or misrepresentation in connection with membership.
- Knowingly furnishes incorrect or incomplete information to us or fails to notify us of changes in family status or Medicare coverage that may affect eligibility or benefits.

We will send written notice to the Subscriber at least 30 days before we rescind your membership, but the rescission will completely cancel your membership so that no coverage ever existed. We will explain the basis for our decision and how you can appeal this decision. You will be required to pay as a non-Member for any Services we covered. Within 30 days, we will refund all applicable Premiums except that we may subtract any amounts you owe us. You may not be allowed to enroll in another Group or individual Plan offered by Health Plan in the future.

You have the right to request an internal appeal of a rescission of coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Member fraud may be reported to the appropriate authorities for prosecution.

### **Termination for Nonpayment**

#### **Nonpayment of Premium**

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we may terminate the memberships of everyone in your Family Unit.

### **Failure of Contribution or Participation Requirements by Employer Groups**

We may terminate this Agreement upon written notice to your Group if the Group fails to adhere to our contribution or participation requirements.

### **Termination for Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area**

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied plan service area, you should contact your Group’s benefits administrator before you move to learn about your Group health care options. You will be terminated from this Plan, but you may be able to transfer your Group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, and Copayments may not be the same in the other service area.

### **Termination for Movement Outside the Service Area**

If you move outside of the any Kaiser Foundation Health Plan Service Area or are away from the Service Area for more than 90 days after you are a Member, you must notify us immediately and your membership will be terminated. If you are a reservist, see “Continuation of Coverage for Reservists” later in this section for more information.

We may terminate this agreement upon 30 days written notice to Group if no eligible person lives within the Service Area.

### **Termination for Noncompliance with Medicare Membership Requirements**

For Members eligible for Medicare as primary coverage, Premiums are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered Services provided to Members eligible for benefits under Medicare Part A and B (or Part B only). If you are or become eligible for Medicare as primary coverage, you must comply with all of the following requirements:

- Enroll in all parts of Medicare for which you are eligible and continue that enrollment while a Member; and
- Be enrolled through your Group in a Kaiser Permanente Medicare Plus plan; and
- Complete and submit all documents necessary for Health Plan, or any provider from whom you receive Services covered by Health Plan, to obtain Medicare payments for Medicare-covered Services provided to you.

If you do not comply with all of the above requirements for any reason, even if you are unable to enroll in a Medicare Plus plan because you do not meet the Plan's eligibility requirements or the plan is not available through your Group, we may increase your Group's Premium. If your Group fails to pay the increase in Premium for your Family Unit then we may terminate the memberships of everyone in your Family Unit.

### **Discontinuation of a Product or All Products**

We may discontinue offering a particular product or all products in a market, as permitted by law. If we discontinue offering in a market the product described in this EOC, we will give 90 days prior written notice to your Group. If we discontinue offering all products to groups in a market, we will give 180 days prior written notice to the Group.

### **Continuation of Group Coverage Under Federal Law (COBRA)**

You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

### **Continuation of Group Coverage Under State Law**

You may be eligible to continue coverage under Ohio law. This continuation of coverage is available only if the Subscriber meets all of the following criteria:

- The Subscriber is not eligible for coverage by Medicare.
- The Subscriber is not eligible for other group medical coverage.
- The Subscriber has been a Member for at least three consecutive months immediately before termination of employment.
- The Subscriber must be involuntarily terminated, other than for gross misconduct.

To continue coverage, you must contact your Group for additional information. This coverage terminates on the earliest of the following occurrences:

- Twelve months after the Subscriber's coverage would have otherwise terminated because of termination of employment.
- The date the Subscriber becomes eligible for Medicare coverage.
- The date the Subscriber becomes eligible for other group medical coverage.
- The date the Group contract with us ends.
- The date the Subscriber no longer meets eligibility requirements.
- Nonpayment of Premiums, contributions, Deductibles, Copayments or other supplemental payments.

### **Continuation of Coverage for Reservists**

Ohio law provides continuation of coverage for military reservists who are called to active duty and their enrolled Dependents. Coverage may be continued for 18 months after the date on which the coverage would otherwise terminate because the reservist is ordered to active duty. This can extend up to 36 months of coverage if any of the following occur within the 18-month period:

## 2013 Group Plan Evidence of Coverage

- Extension due to death of the reservist.
- Extension due to divorce or separation of the reservist from the reservist's Spouse.
- Extension for an enrolled child Dependent who loses eligibility as a Dependent under the terms of this plan.

Coverage terminates on the earliest of the following dates.

- You become covered under another group contract that does not contain preexisting conditions.
- You have exhausted the time limits for eligibility under this provision.
- The date the Group contract with us ends.

Contact your Group for additional information. All other eligibility and payment provisions apply.

### **USERRA (Uniformed Services Employment and Reemployment Rights Act)**

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

### **Conversion of Membership**

You may be eligible to convert to the Conversion plan or join another Kaiser Permanente plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Eligibility and Enrollment" section or if you enroll in COBRA or USERRA continuation coverage and then lose eligibility for that COBRA or USERRA coverage. However, you may not convert to a non-group plan if:

- You continue to be eligible for coverage through your Group.
- Your membership ends because our Agreement with your Group terminates.
- We terminated your membership under "Termination for Cause" in this "Termination of Membership" section.

You must apply to convert your membership within 30 days after your Group or Health Plan notifies you that your coverage ends. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay Premiums and the benefits, Deductibles, and Copayments under the non-group coverage may differ from those under this EOC.

For information about converting your membership or about other non-group plans, call Customer Relations at (216) 621-7100 or 1-800-686-7100 (**1-877-676-6677 – TTY for the hearing/speech impaired**).

### **Federally Eligible Individual**

This is an individual who meets the following specified conditions.

- Has at least 18 months of "creditable coverage," the most recent of which was under a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with such a plan); and
- Is not eligible for coverage under another group health plan, Medicare, or Medicaid and does not have any other health insurance coverage; and
- Their most recent coverage was not terminated because of fraud or nonpayment of Premiums; and
- Either was not offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or a similar state program, or if COBRA or similar state-mandated continuation coverage was offered, elected and exhausted such continuation coverage.

The individual may be eligible for conversion to one of the following:

- Our "HIPAA Basic Plan," for federally eligible individuals, established by the Board of Directors of the Ohio Health Reinsurance Program; or,
- Our "HIPAA Standard Plan," for federally eligible individuals, also established by the Board of Directors of the Ohio Health Reinsurance Program.

Application must be made within 63 days of losing the current Group coverage. Deductibles, Copayments benefits, and Premiums may differ under these plans from those currently provided under Group coverage. For more information regarding

these options, please call Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**.

## **Miscellaneous Provisions**

### **Administration of Agreement**

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Group Agreement and this EOC.

### **Advance Directives**

You have the right to make decisions about your health care. You can put your wishes in writing as an advance directive. Ohio law recognizes Living Wills in which you write what medical care you would want to receive or refuse if you become unable to make health care decisions for yourself. You may also use a Health Care Power of Attorney, to name someone to make health care decisions for you if you are unable to do so. If you would like an informational packet about Advance Directives you may call Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**.

### **Agreement Binding on Members**

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

### **Amendment of Agreement**

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to make revised materials available to you.

### **Applications and Statements**

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

### **Assignment**

You may not assign this EOC or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

### **Attorney Fees and Expenses**

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

### **Certificate of Creditable Coverage**

Creditable coverage includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Services, a state health benefits risk pool, FEHBP, the Peace Corps Act, a publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care, or any other creditable coverage as defined by the Federal Public Health Services Act. Creditable coverage gives an individual credit for past health coverage. To be eligible for creditable coverage an individual cannot have a break in coverage of 63 days or more. The certificate of creditable coverage is intended to establish an individual's prior creditable coverage for purposes of reducing the extent to which a plan or issuer offering health coverage in the group market can apply a preexisting condition exclusion. We or your Group will send you a certificate to cover you and your eligible Family Dependents when your coverage ends with us, and when your COBRA or other continuation of coverage begins and ends with us, and other times upon your request.

### **Claims Review Authority**

We are responsible for determining whether you are entitled to benefits under this EOC. We have the discretionary authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

### **Contracts With Plan Providers**

Health Plan and Plan Providers are independent contractors. Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider, in excess of any applicable Deductibles and Copayments until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

### **Collection Costs**

Deductibles and Copayments (and other charges, for example, for non-covered Services) are due when you receive Services. An administrative fee may be charged if any amount you owe is not paid at the time of Service. This administrative fee does not apply to Emergency Services or Copayments that are calculated on a percentage of the cost of a Service. If we are required to enforce a lien on a settlement or judgment in order to recover costs for Medical Services you received, you must reimburse us for the reasonable costs of collection, including any attorneys' fees.

### **Governing Law**

Except as preempted by federal law, this EOC will be governed in accord with State of Ohio law and any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

### **Group and Members not Health Plan's Agents**

Neither your Group nor any Member is the agent or representative of Health Plan.

### **Named Fiduciary**

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this EOC. In addition, as a named fiduciary, we have the discretionary authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

### **New Technology Assessment**

When a new medical technology or procedure needs review, our Inter-regional New Technology Committee examines and evaluates data from government agencies, medical experts, medical journals, and medical specialty societies. Recommendations from this Inter-regional Committee then are passed on to the local Committee. The Committee reviews the national recommendations to see how they apply to local medical practices. Once this review takes place, the Committee makes recommendations for the new technology or procedure to become a covered benefit. In addition, the Committee communicates practice guidelines to Plan Providers and related health care providers. If the Committee's recommendation is accepted, the new technology is added to the covered benefits, either immediately or when this contract renews.

### **No Waiver**

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

### **Nondiscrimination**

We do not discriminate in our employment practices or in the delivery of health care services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability. If you would like more information contact Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**.

### **Notices**

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)** as soon as possible to give us their new address.

All notices sent to us must be sent by U.S. Mail and addressed to:

Kaiser Foundation Health Plan of Ohio  
P.O. Box 5309  
Cleveland, Ohio 44101

### **Overpayment Recovery**

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

### **Privacy Practices**

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your PHI, request corrections or updates to your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, please call Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**. You can also find the notice at your local Plan Facility or on our website found in the Annual Member Notice at [kp.org/formsandpubs](http://kp.org/formsandpubs).

## **Definitions**

The following terms, when capitalized and used in any part of this EOC, mean:

**Affiliated Physician/Provider:** A physician or allied professional in the community who has entered into an agreement with the Ohio Permanente Medical Group to provide covered Services to our Members.

**Complaint:** A verbal or written expression of dissatisfaction from a Member.

**Copayment:** A specified dollar amount or percentage of covered expenses (coinsurance) that you must pay when you receive a covered Service as listed in the "Deductible, Copayments, and Out-of-Pocket Maximum" section.

**Deductible:** A specified dollar amount that you must pay for covered Services before Health Plan will pay any amount toward covered Services in the calendar year.

**Dependent:** A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility and Enrollment" section).

**Eligible Cancer Clinical Trial:** (1) The purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes, (2) the treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes, (3) the trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology, (4) the trial does one of the following: (a) tests how to administer a health care service, item, or drug for the treatment of cancer; (b) tests responses to a health care service, item, or drug for the treatment of cancer; (c) compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or (d) studies new uses of a health care service, item, or drug for the treatment of cancer; and, (5) the trial is approved by the national institutes of health or one of its cooperative groups or centers under the United States department of health and human services, the United States food and drug administration, the United States department of defense, or the United States department of veterans' affairs.

**Eligible Charges:** (1) For Services that Health Plan or Medical Group provides and for Services for which any other Plan Provider is compensated on a capitated basis, the applicable KP Rate for the particular Service; (2) for items covered under "Drugs and Supplies" and obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy

## 2013 Group Plan Evidence of Coverage

would charge a Member for the item if the Member's benefit plan did not cover the item. This amount is based on the cost of acquiring, storing and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan; or (3) for all other Services, the payments that Kaiser Permanente made for the Services or, if Kaiser Permanente subtracts a Copayment from its payment, the amount Kaiser Permanente would have paid if it did not subtract the Copayment.

**Emergency Medical Condition:** 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 any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

**Emergency Services:** All of the following with respect to an Emergency Medical Condition:

- A medical screening examination (as required under the **Emergency Medical Treatment and Active Labor Act**) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the **Emergency Medical Treatment and Active Labor Act** requires to Stabilize the patient

**Essential Health Benefits:** Defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Plans may contain some or all of these types of benefits prior to 2014 when they become mandatory. If plans contain any of these benefits, there are requirements that may apply to these benefits.

**Family Unit:** A Subscriber and all of his or her Dependents.

**Grievance:** A Complaint with a request for a health care service and/or payment, prior to a denial letter being issued.

**Health Plan:** Kaiser Foundation Health Plan of Ohio.

**Kaiser Permanente:** Kaiser Foundation Health Plan of Ohio; Ohio Permanente Medical Group, Inc.

**KP Rate:** The amount from our schedule of charges that is used to calculate your Eligible Charges for Services including Services that Health Plan or Medical Group provides and for which any other Plan Provider is compensated on a capitated basis.

**Medical Group:** Ohio Permanente Medical Group, Inc.

**Medically Necessary:** Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; are not mainly for the convenience of you or your doctor; and, their omission would adversely affect your health.

**Medicare:** A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

**Member:** A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to Member as "you" or "your."

**Plan:** Kaiser Foundation Health Plan of Ohio.

**Plan Facility:** A Plan Medical Office, or Plan Hospital, or a medical office of an Affiliate Physician. Please refer to the Provider Directory for the types of covered Services available from each Plan Facility.

## 2013 Group Plan Evidence of Coverage

**Plan Hospital:** Any hospital with which we contract to provide specific Services for Members in our Service Area when provided or authorized by a Plan Physician. For a listing of hospitals we contract with to provide Service for you, please see the Provider Directory

**Plan Medical Office:** Any outpatient treatment facility staffed by Ohio Permanente Medical Group Physicians.

**Plan Pharmacy:** Any pharmacy located at a Plan Facility or another pharmacy that we designate.

**Plan Physician:** Any licensed physician who is an employee of Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

**Plan Provider:** A Plan Hospital, Plan Physician, or other health care provider that contracts to provide Services to Members (but not including providers who contract only to provide referral Services).

**Premiums:** Periodic membership charges paid by your Group.

**Rescission:** Retroactive termination of membership and the memberships of all Dependents (or the offending Dependent) after it becomes effective, as if no coverage ever existed, as defined under the Patient Protection and Affordable Care Act of 2010 (PPACA) as then constituted or later amended.

**Routine Patient Care:** All health care services consistent with coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial. Routine Patient Care must be prescribed, provided, or authorized by a Plan Physician.

**Service Area:** Our Service Area includes the following counties in the state of Ohio: Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, Stark, Summit and Wayne. This may include contiguous counties if purchased by the Group. Refer to the “Additional Information or Other Benefits Requested by Your Group” section to determine if contiguous counties apply to this plan.

**Services:** Health care services or items.

**Skilled Nursing Facility:** A facility that is an institution that provides primarily 24 hour a day licensed inpatient skilled nursing care or skilled rehabilitation Services, has in effect a transfer agreement with one or more hospitals, is licensed under the State of Ohio, certified by Medicare, and approved by Health Plan. The term “Skilled Nursing Facility” does not include a facility that furnishes primarily custodial care, including training in routines of daily living.

**Spouse:** Your legal husband or wife.

**Stabilize:** To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), “Stabilize” means to deliver (including the placenta).

**Subscriber:** A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see “Who Is Eligible” in the “Eligibility and Enrollment” section).

## Appendix

### Utilization Review

Utilization review, which is performed by our Medical Management Department, is a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Utilization review exists to assist you in receiving appropriate covered medical care. Utilization review takes place whether you receive your covered medical care from Plan Providers, Affiliated Providers or as the result of a Referral or a covered Emergency Service. As part of our utilization review, we use review criteria that are based on sound clinical evidence. These

criteria are evaluated periodically to assure ongoing efficacy. Qualified registered nurses and Plan Physicians perform utilization review. The review team insures that clinical review criteria are consistently applied. The team also measures and evaluates the clinical appropriateness of adverse determinations that are subject to the appeal process. Individuals responsible for utilization management decisions do not receive any financial incentive or additional compensation for such decisions.

**Pre-Service Review**

Pre-service review is utilization review conducted before health care services are provided to a Member.

**Concurrent Review**

Concurrent review is utilization review conducted during a patient’s hospital stay, Skilled Nursing Facility stay, or any other ongoing course of treatment.

**Post-Service Review**

Post-service review is utilization review conducted after health care services have been provided to a Member.

**Note:** If we deny a pre-service request for covered, Medically Necessary medical care, or if during the course of a concurrent review we deny further inpatient or outpatient treatment, the provider, with the Member’s consent, may request a reconsideration of the denied Services. We will reconsider the denied Services within three working days (or less depending on the seriousness of your medical condition) after our receipt of the request for reconsideration. If our decision is to uphold the initial denial, you or the provider, on your behalf, with your signed authorization or representation, may appeal the denial of requested Services in writing. See the “Getting Assistance, Claims and Appeals Procedure and Dispute Resolution” section for ways to appeal.

**Note:** You or your authorized representative may submit an appeal if we fail to make and communicate a determination within the timeframes for pre-service, concurrent, or post-service review. Failure by us to make a determination and notification within the timeframes stated in the Claims and Appeals Procedure will be considered to be a denial for the purpose of initiating an appeal.

If you have questions about our utilization review procedures please contact Customer Relations at (216) 621-7100 or 1-800-686-7100 **(1-877-676-6677 – TTY for the hearing/speech impaired)**.

**Small Group Waiting Periods**

We do not impose a waiting period. Your Small Group may have a waiting period. This waiting period may not exceed 90 days.

**When Medicare Is Primary and Secondary**

**Persons for Whom Medicare Is Primary**

The monthly membership charge for our coverage is based on the assumption that we will receive payment from Medicare for services provided to Members entitled to Medicare benefits. Persons eligible for Medicare benefits must submit to us all consents, releases, authorizations, and other documents necessary for us to obtain Medicare reimbursement. Any Member who fails to do so must pay for services, or, at our discretion, a surcharge will be applied to his or her membership charges.

There are a number of categories of Members for whom Medicare coverage is primary, meaning that Medicare pays for covered Services before we do, and that our benefits are secondary to any benefits to which the Member is entitled under Medicare. Therefore, references to Medicare in this EOC apply to the following categories of Members for whom Medicare is primary over us.

1. Medicare is primary for Subscribers who work for employers of 19 or fewer employees and who, or whose Spouses, qualify for Medicare due to reaching age 65.
2. Medicare is primary for Members who qualify for Medicare solely due to end stage renal disease. Medicare becomes primary over us only after the first 30 consecutive months of a regular course of renal dialysis after Medicare entitlement; or after 36 consecutive months after a kidney transplant.
3. Medicare is primary for Subscribers who work for employers of 99 or fewer employees and who, or whose Dependents, qualify for Medicare because of disability.
4. Medicare is primary for retirees who qualify for Medicare. Check with your Group to see if retiree coverage is available to you.

### Persons for Whom Medicare Is Secondary

Medicare is secondary for Subscribers who work for employers of 20 or more employees, and who, or whose Spouses, qualify for Medicare due to reaching age 65. Federal law applicable to employers of 20 or more employees requires that their Medicare-eligible employees age 65 and over decide (for both self and Medicare-eligible Spouse) either (a) to continue the employer-sponsored group health benefits coverage or (b) to select Medicare as primary coverage. (When the employee is under 65 and the Spouse is age 65 or over, this decision must be made for the Spouse alone). If the employee decides to continue the employer-sponsored group health coverage, then our coverage is provided on the same basis as for Group Members under 65. Such Health Plan coverage would be “primary,” meaning that we pay for covered Services before Medicare does. In such cases, Medicare benefits are secondary to any benefits to which the Member is entitled as a Health Plan Member. If the employee selects Medicare as primary, the employee and Spouse cease to be covered by the employer-sponsored health benefits coverage, including Health Plan. Federal law applicable to employers of 100 or more employees requires that the employer-sponsored group health benefits coverage is primary over Medicare for employees or their Dependents that qualify for Medicare due to disability. This means that we pay for covered Services before Medicare does, and that Medicare benefits are secondary to any benefits to which the Member is entitled as a Health Plan Member. Therefore, references to Medicare in this EOC do not apply to any such Member who selects Health Plan coverage to be primary over Medicare or a disabled Member for whom we are primary over Medicare.

## Deductible, Copayments and Out-of-Pocket Maximum

This section discusses:

- The Deductible and Copayments you are responsible for paying.
- Benefit maximums including dollar, visit, or time period maximums.
- Dependent age limit.
- Dependent student age limit.
- Deductible and Out-of-Pocket time period.
- Out-of-Pocket Maximum limit.

This section does not describe benefits. To learn what is covered for each benefit (including exclusions and limitations), please refer to the identical heading in the “Benefits” section. Be sure to check the next section “Additional Information or Other Benefits Requested by Your Group,” for additional benefits not described in the “Benefits” or “Deductible, Copayments, and Out-of-Pocket Maximum” sections.

**Note:** There are no lifetime limits on Basic Health Care Services nor are there lifetime or annual dollar limits for Essential Health Benefits.

### Deductible

A Deductible is a specified dollar amount that you must pay for covered Services before Health Plan will pay any amount toward covered Services in a year.

For Services that are subject to the Deductible, you must pay Eligible Charges for the Services when you receive them, until you meet the Deductible for that calendar year. The only payments that count toward the Deductible are those you make for Services that are subject to the Deductible, but only if the Services would otherwise be covered.

The single Deductible applies separately to each Member in the Family Unit and will be due until either the Member satisfies his or her single Deductible or the total payments by Members in the Family Unit applied toward their single Deductibles reach the family Deductible. This means that once the family Deductible is satisfied, no further single Deductible will be due for the remainder of the calendar year. See the Copayment chart for the single and family Deductibles.

After the Deductible is satisfied, you pay the applicable Copayment for the certain Services for the remainder of the calendar year, subject to the limits described under “Annual Out-of-Pocket Maximum.” The Deductible does not count toward the satisfaction of the annual Out-of-Pocket Maximum. See the Copayment chart for your plan Deductible and, the time period used to calculate the Deductible, and the benefits that are subject to the Deductible.

We recommend that you keep your receipts for Services received.

**Copayments**

Copayments are due at the time of your visit. Copayments calculated on a percentage are based on the Eligible Charges for the covered Services. Refer to the definition of Eligible Charges shown in the “Definitions” section of this EOC.

A Copayment for Basic Health Care Services will not exceed 40% of the average cost of the Service. The average cost of a Service is calculated by dividing the Eligible Charges by the total number of the Services paid by Kaiser Permanente.

**Note:** We reserve the right to reschedule non-urgent care if you do not pay the Deductible or Copayment at the time of your visit.

**Annual Out-of-Pocket Maximum**

There are limits to the total amount of Copayments you must pay in a calendar year for certain Services covered under this EOC. The limits are listed in the Copayment chart that follows. Copayments for Basic Health Care Services apply toward these limits. The Copayment chart identifies Basic Health Care Services with an asterisk (\*). Copayments for Basic Health Care Services cannot exceed 200% of the average annual Premium rate to the Subscriber or enrollees.

The single Out-of-Pocket Maximum applies separately to each Member in your Family Unit. If the family Out-of-Pocket Maximum shown in the Copayment chart is satisfied by Members in your Family Unit, then the Out-of-Pocket Maximum will be considered to have been reached for all Members in your Family Unit and no further Copayments will be due during the calendar year for Services for which Copayments are applied toward the Out-of-Pocket Maximum. We recommend that you keep your receipts for Services received.

See the Copayment chart on the next page.

Group

<b>Benefit:</b>	<b>Member Pays</b>
<b>Outpatient Care*</b>	
Primary Care office visits	\$15 per visit
Specialty Care office visits (including post natal visits), Allergy consultations and testing visits, Surgical procedures performed in the office, Anesthesia, Pain Management	\$15 per visit
Prenatal office visits	Nothing
Respiratory therapy	10% but no more than \$1000/member or \$2000/family**
Chemotherapy, Radiation therapy	10% but no more than \$1000/member or \$2000/family**
Allergy treatment	\$5 per visit
Outpatient surgery	10% but no more than \$1000/member or \$2000/family**
House calls by a physician	Nothing
Blood, blood products and their administration,	10% but no more than \$1000/member or \$2000/family**
Medical Social Services	Nothing
<b>Hospital Inpatient Care*</b>	10% but no more than \$1000/member or \$2000/family**
<b>Ambulance*</b>	10% but no more than \$1000/member or \$2000/family**
<b>Chemical Dependency</b>	
Inpatient Detoxification in a general hospital	10% but no more than \$1000/member or \$2000/family**
Inpatient Detoxification in a Specialized Facility	10%
Outpatient Detoxification	\$15 per visit
Outpatient Individual Therapy	\$15 per visit
Outpatient Group Therapy	\$5 per visit; \$5 per day max
<b>Dialysis*</b>	10% but no more than \$1000/member or \$2000/family**
<b>Drugs and Supplies</b>	See "Benefits" section
<b>Durable Medical Equipment (DME), External Prosthetics and Orthotics</b>	10%
<b>Emergency Services*</b>	
Emergency Services at a Plan Facility	\$50 per visit (waived if admitted)
Emergency Services at a non-Plan Facility	\$50 per visit (waived if admitted)
Follow up Care to Emergency Services Outside the Service Area	All charges beyond \$500 per calendar year
<b>Family Planning*</b>	\$15 per visit
<b>Hearing</b>	Same as Specialty Care office visits
<b>Home Health</b>	10%
<b>Hospice</b>	Nothing
<b>Infertility Services*</b>	
Inpatient	10% but no more than \$1000/member or \$2000/family**
Outpatient	10% but no more than \$1000/member or \$2000/family**
<b>Laboratory, X-Ray and Other Diagnostic Services*</b>	10% per service**
<b>Mental Health Services</b>	
Biologically Based Mental Illness*	

Group

<b>Benefit:</b>	<b>Member Pays</b>
Inpatient	10% but no more than \$1000/member or \$2000/family**
Outpatient	\$15 per visit
Outpatient Group Therapy	\$7 per visit
<b>Other Mental Health Illnesses</b>	
Inpatient	10%; Unlimited days
Outpatient Individual Therapy	\$15 per visit
Outpatient Group Therapy	\$7 per visit
Inpatient Alternative Services	\$15 per visit
<b>Outpatient Physical, Occupational and Speech Therapy, Cardiac and Multidisciplinary Rehabilitation</b>	
Physical Therapy	10%; Limit of 30 visits per calendar year
Occupational Therapy	10%; Limit of 30 visits per calendar year
Speech Therapy	10%; Limit of 30 visits per calendar year
Cardiac Rehabilitation	10% per visit
Multidisciplinary Rehabilitation	10%; Limit up to two consecutive months
<b>Preventive Exams and Services*</b>	
Preventive exams performed by a PCP	Nothing
Preventive exams performed by a Specialist Includes female family planning counseling, sterilization procedures and implants	Nothing
Flexible Sigmoidoscopy and Screening Colonoscopy	Nothing
<b>Preventive Care Services mandated by the Patient Protection and Affordable Care Act*</b>	
Well-child care exams for children through age 21	Nothing
Preventive health screening tests Fecal occult blood, Chlamydia, Cholesterol Test (Lipid Profile) Fasting Blood Glucose, Pap Test, and HPV	Nothing
Mammograms	Nothing
Immunizations (except travel immunizations)	Nothing
<b>Prosthetic Devices (Internally Implanted)</b>	10% but no more than \$1000/member or \$2000/family**
<b>Reconstructive Surgery*</b>	
Inpatient	10% but no more than \$1000/member or \$2000/family**
Outpatient	\$15 per visit
<b>Skilled Nursing Facility</b>	10%; Limit 100 days per calendar year
<b>Transplant Services*</b>	
Inpatient	10% but no more than \$1000/member or \$2000/family**
Outpatient	\$15 per visit
<b>Urgent Care Services *</b> In a Plan urgent care facility within the Service Area or any urgent care facility outside the Service area.	\$15 per visit
<b>Vision Services</b>	Same as Specialty Care office visits
<b>Dependent Age Limit</b>	up to age 26 end of birth month
<b>Student Dependent Age Limit</b>	up to age 26 end of birth month
<b>Annual Deductible</b>	
Single	Nothing
Family	Nothing

## Group

<b>Benefit:</b>	<b>Member Pays</b>
<b>Annual Out of Pocket Maximum</b>	
Single	\$5,000
Family	\$10,000

\*These are Basic Health Care Services and the Copayment for each will not exceed 40% of the average cost of the Service. The average cost of a Service is calculated by dividing the Eligible Charges by the total number of the Service paid by Kaiser Permanente.

\*\*Benefits accumulate to the member/family maximum.

### **Additional Information or Other Benefits Requested by Group (if any)**

#### **DURABLE MEDICAL EQUIPMENT/PROSTHETIC DEVICES/ORTHOTIC APPLIANCES**

Durable medical equipment, prosthetic devices and orthotic appliances currently approved under Medicare criteria and our DME/Prosthetic Devices/Orthotic Appliances Formulary as of January 1, of the year immediately preceding the year in which your contract was effective or last renewed, are provided upon payment by the Member of 10% of our allowance, when prescribed in writing by a Plan Physician and obtained from a provider approved by Health Plan. These include:

- Durable Medical Equipment that is necessary to serve a medical purpose, can withstand repeated use, is appropriate for use in the home, and which is generally not useful to a person in the absence of illness or injury. Examples include: hospital beds, crutches, canes, and wheelchairs.
- Prosthetic Devices that replace all or part of a body organ or that replace all or part of the function of a permanently inoperative or malfunctioning body organ.
- Orthotic Devices that support a weak or deformed body member or for restricting or eliminating motion in a diseased or injured part of the body.
- Supplies and equipment essential to the use of the above mentioned items.
- Replacement or repairs, except in circumstances listed under Exclusions.

**Exclusions.** The following equipment and supplies are **NOT COVERED**:

- Dental appliances, hearing aids, eyeglasses, arch supports, foot orthotics, corrective shoes, nonrigid appliances and supplies such as elastic stockings and garter belts.
- Experimental or research devices and appliances.
- Replacement or repair necessitated by misuse or loss that is covered under any insurance policy or by any governmental program.
- Educational training in the use of prosthetic devices and orthotic appliances.
- Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a Member's condition and required in order for the Member to operate the equipment.
- Equipment usually used for comfort or convenience that is not primarily medical in nature e.g., bed boards, patient over- bed tables, telephone arms, air conditioners, or portable vs. stationary equipment.
- Physicians' equipment e.g., infusion pump, sphygmomanometer (blood pressure cuff), stethoscope.
- Exercise and hygienic equipment e.g., exercycle, Moore Wheel, Bidet toilet seats, bathtub seats.
- Self-help devices not primarily medical in nature e.g., sauna baths, elevators.

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#### **OUTPATIENT PRESCRIPTION DRUG BENEFIT**

Drugs are covered when a prescription is required by law. Drugs and accessories are covered only when medically necessary for treatment of a specific illness, injury or condition; prescribed by a licensed health care professional authorized to prescribe drugs; and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies. This includes coverage for off-label formulary or nonformulary drug usage in the treatment of a particular condition for a drug that is approved by the United States Food and Drug Administration and is recognized as safe and effective for that condition in published, authoritative medical, scientific, or pharmaceutical literature.

Prescribed covered drugs and accessories are provided at a single Copayment for each prescription, not to exceed the amount prescribed, up to a 31-day supply except that, if the regular charge is less than the Copayment, Members pay the regular charge. Each prescription refill is provided on the same basis as the original prescription. If a prescription or refill is for a quantity greater than the limits described above, the charge is an additional Copayment for each multiple quantity or fraction of a 31-day supply. We reserve the

## Group

right to dispense only a 31-day supply when the prescription or refill is of a quantity greater than a 31-day supply. We provide up to a 31-day supply based upon (a) the prescribed dosage, (b) the standard manufacturers' package size, and (c) specified dispensing limits.

### Formulary Drugs

Kaiser Permanente uses a formulary. This is a list of drugs that Kaiser Permanente has found to be effective, safe and useful in caring for members while helping to keep the cost of prescription drugs affordable. Drugs are covered at the Copayment for formulary drugs listed below when they are listed in the Health Plan Drug formulary. Coverage of certain formulary medications may also be subject to restrictions established by the Pharmacy and Therapeutics Committee. Nonformulary drugs will be covered in the same manner as formulary drugs when (i) the Plan Physician documents in the Member's medical record and certifies that the formulary alternative has been ineffective in the treatment of the Member's disease or condition or (ii) that the formulary alternative causes or is reasonably expected by the Plan Physician to cause harmful or adverse reactions and (iii) the use conforms to guidelines and criteria reviewed and approved by the Kaiser Permanente Health Plan of Ohio's Pharmacy and Therapeutics Committee. If prescribed by a physician, a small number of non-prescription drugs (listed in the Health Plan Drug formulary) and accessories are also covered: insulin, disposable insulin syringes/needles and certain cough syrups. Any questions regarding drugs listed in the Health Plan Drug formulary can be directed to a Kaiser Permanente Pharmacist or an affiliated pharmacist.

### Nonformulary Drugs

Nonformulary drugs will be covered at the Copayment for nonformulary drugs listed below.

### Brand-name and Generic Drugs

Coverage includes brand-name and generic drugs. Brand-name drugs are drugs that are produced and sold under the original manufacturer's brand-name. Generic drugs are produced and sold under their chemical names after the patent of the brand-name drug expires. A compounded drug is one in which two or more drugs or pharmaceutical agents are combined together to meet the requirements of a prescription. When there is a Copayment differential between brand-name and generic drugs, the applicable generic or brand-name drug Copayment will apply depending on the compound drug's main ingredient, whether the main ingredient is a generic or brand-name drug.

### Direct Mail Services

Plan pharmacies include our direct mail pharmacy Services. Our direct mail Service offers delivery to residents of Ohio. Drugs that have a significant potential for waste or misuse and those that we determine are in limited supply in the market will be provided through direct mail for up to a 31-day supply. Covered prescriptions for maintenance medications may be ordered by mail up to a 90-day supply. A maintenance medication is a prescription drug used on an ongoing basis. With the exception of insulin, certain medications, such as those requiring refrigeration and certain controlled medications are not available through direct mail. Items available through our direct mail pharmacy are subject to change at any time without notice. Items available through our direct mail pharmacy are subject to change at any time without notice. A single Copayment will be collected for up to a 90-day supply if your Plan Physician writes for the appropriate quantity of medication as follows:

\$10.00 for formulary generic drugs,  
\$40.00 for formulary brand-name drugs,  
\$70.00 for nonformulary brand-name drugs (when no generic is available),  
\$70.00 for nonformulary generic drugs or the cost of the generic drug whichever is less,  
\$70.00 plus the difference in price between the brand-name and the generic drug for nonformulary brand-name drugs (when generic is available).

**General Exclusions:** The following are not covered under this outpatient prescription drug benefit:

- (a) Drugs when prescribed for cosmetic purposes.
- (b) Drugs that are necessary for or related to an excluded service.
- (c) Drugs used for the purpose of weight loss.
- (d) Drugs and materials that require administration by medical personnel or observation by medical personnel during or after administration.
- (e) Non prescription drugs and medications (however, non prescription nicotine replacement products are covered when on our formulary).
- (f) Nonformulary nicotine replacement products.
- (g) Investigational or experimental drugs or drugs that are limited to investigational use.
- (h) Replacement of lost or damaged prescriptions.
- (i) Unless an exception is approved by Health Plan, drugs not approved by the FDA and in general use as of March 1<sup>st</sup>, of the year immediately preceding the year in which this Agreement became effective or was last renewed.
- (j) Drugs used to enhance athletic performance.
- (k) Medical Supplies such as dressings and antiseptics.
- (l) Vitamins and nutritional supplements that can be purchased without a prescription.
- (m) Special medication packaging, other than Health Plan standard packaging.
- (n) Drugs used to shorten the duration of the common cold.

## Group

(o) Medical Foods.

**Prescribed Drugs (Except For Those Prescribed Drugs Used for the Treatment of Involuntary Infertility and for the Treatment of Sexual Dysfunction).** Prescribed covered drugs and accessories are provided at a Copayment of:

\$5.00 for formulary generic drugs,  
\$20.00 for formulary brand-name drugs,  
\$35.00 for nonformulary brand-name drugs (when no generic is available),  
\$35.00 for nonformulary generic or the cost of the generic drug whichever is less,  
\$35.00 plus the difference in price between the brand-name and the generic drug for nonformulary brand-name drugs (when generic is available).

**Prescribed Drugs Used for the Treatment of Involuntary Infertility.** Prescribed covered drugs and accessories used for the treatment of involuntary infertility are provided at a Copayment of 50% of Eligible Charges.

**Prescribed Drugs Used for the Treatment of Sexual Dysfunction.** Prescribed drugs and accessories used for the treatment of sexual dysfunction are not covered.

**Prescribed Specialty Drugs.** Prescribed covered specialty drugs and accessories are provided at a Copayment of \$20.00.

**Contraceptives.** Contraceptives for which a prescription is required by law and which are listed in the Health Plan Drug Formulary are covered as follows:

Prescribed contraceptive drugs (including topical contraceptives) are provided at a Copayment of \$0/\$0/\$35.00/\$35.00+ per prescription or refill.

Diaphragms are provided upon payment of a \$0/\$0/\$35.00/\$35.00+ Copayment, per prescription or refill when prescribed by a Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies.

IUDs are provided when prescribed by a Medical Group Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies, upon payment of a charge determined by multiplying the \$0/\$0/\$35.00/\$35.00+ Copayment by the number of months that the IUD will be effective, as stated by the manufacturer, except that the charge will not exceed the cost of the IUD or \$200.00 whichever is less.

Internally implanted time-released or intravaginal contraceptives, are provided when prescribed by a Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies, upon payment of a charge determined by multiplying the \$0/\$0/\$35.00/\$35.00+ Copayment by the number of months that the contraceptive will be effective, as stated by the manufacturer, except that the charge will not exceed the cost of the contraceptive or \$200.00 whichever is less.

Injectable contraceptives, are provided when prescribed by a Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies, upon payment of a charge determined by multiplying the \$0/\$0/\$35.00/\$35.00+ Copayment by the number of months that the contraceptive will be effective, as stated by the manufacturer, except that the charge will not exceed the cost of the contraceptive.

There will be no refund on any portion of the Copayment applied to a contraceptive described above, if the contraceptive is removed for any reason before the end of its expected life. Other Medical Services associated with providing contraceptives, such as evaluation, instruction, insertion, fitting, laboratory testing, etc. are provided upon payment of a Copayment, if any, as shown on your Copayment chart.

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### SURVIVING SPOUSE COVERAGE

The surviving spouse of a Subscriber may continue Group coverage by assuming Subscriber status, providing:

the spouse was enrolled under this Evidence of Coverage as a dependent of the Subscriber on the date of the Subscriber's death; and  
the Subscriber was covered under an employer contract requiring continuation of employer paid health coverage after death in instances where the Subscriber was a full-time employee either killed in the line of duty or who died as a direct and proximate result of the performance of official work-related duties; and  
the Subscriber's death occurred on or after January 1, 2010.

All other dependents of the Subscriber who currently meet eligibility requirements of this Evidence of Coverage may continue Group coverage by becoming dependents of the surviving spouse.

# Group

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