

Table of Contents

Introduction	2	Transplant Services.....	13
Welcome to Kaiser Permanente.....	2	Urgent Care Services.....	14
About This Evidence of Coverage (EOC)	2	General Exclusions/Limitations/Reductions	14
Eligibility and Enrollment.....	2	Exclusions.....	14
Who Is Eligible	2	Limitations.....	16
Enrollment and Effective Date of Coverage	3	Reductions	16
Payment of Premium	4	Getting Assistance, Claims and Appeals Procedure,	
How to Obtain Services	4	and Dispute Resolution	21
Your Primary Care Physician	5	Getting Assistance	21
Getting a Referral	5	Claims and Appeals Procedure.....	21
Second Opinions.....	6	Dispute Resolution	26
Plan Facilities	6	Termination of Membership.....	26
Getting the Care You Need.....	6	Termination by Member.....	26
Visiting Other Kaiser Foundation Health Plan or Allied		Termination Due to Loss of Eligibility.....	26
Plan Service Areas.....	7	Termination for Fraud or Intentional Misrepresentation	27
Using Your Identification Card	7	Misrepresentation on Application.....	27
Benefits	7	Termination for Nonpayment	27
Outpatient Care.....	8	Termination for Moving to Another Kaiser Foundation	
Hospital Inpatient Care.....	8	Health Plan or Allied Plan Service Area	27
Ambulance.....	9	Termination for Movement Outside the Service Area....	27
Dialysis.....	9	Discontinuation of a Product or All Products.....	27
Drugs and Supplies.....	10	Continuation of Coverage for Reservists.....	27
Durable Medical Equipment (DME), External Prosthetics		Conversion of Membership	28
& Orthotics.....	10	Miscellaneous Provisions.....	28
Emergency Services.....	10	Definitions	30
Family Planning.....	11	Appendix	33
Hearing.....	11	Utilization Review	33
Infertility Services	11	Deductible, Copayments, and Out-of-Pocket	
Laboratory, X-ray, and Other Diagnostic Services.....	12	Maximum	33
Mental Health Services.....	12	Deductible.....	33
Preventive Care Services	12	Copayments	34
Prosthetic Devices (Internally Implanted)	13	Annual Out-of-Pocket Maximum	34
Reconstructive Surgery.....	13		

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)

The HIPAA Basic Plan Application and this Evidence of Coverage describes the “Kaiser Permanente Deductible/Copayment” health care coverage you have through a contract (Agreement) between you and Kaiser Foundation Health Plan of Ohio. If you are the person who applied for Health Plan membership and agree to be responsible for payment, you are the “**Subscriber**.” The word “**you**” and “**Member**” means the Subscriber, each dependent enrolled under this Agreement and any other dependents that later become eligible. By paying monthly Premiums your membership continues from month to month. Members and applicants for membership must complete any applications, forms or statements that we reasonably request.

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 you continue to pay monthly Premiums or accept benefits after the changes have gone into effect, you thereby agree 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.” 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.

Eligibility and Enrollment

Who Is Eligible

General

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

- You must permanently reside in our Service Area (our Service Area is described in the “Definitions” section). 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.
- You must be a Federally Eligible Individual. A Federally Eligible Individual is an individual who(se):
 - Has at least 18 months of “creditable coverage,” (with the exception of newborns or newly adopted children) the most recent of which was under a group or individual 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;
 - Most recent coverage was not terminated because of fraud or nonpayment of premiums and;
 - Was either 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, has elected, and exhausted such continuation coverage and;
 - Has not had a break in coverage of 63 days or more.

Rescission of Membership

We may rescind your membership after it becomes effective (completely cancel your membership so that no coverage ever existed) if you or anyone seeking coverage on your behalf did any of the following before your membership became effective:

2011 HIPAA Basic Plan Evidence of Coverage

- Performed an act, practice, or omission that constitutes fraud in connection with your membership or application for membership.
- Made an intentional misrepresentation of material fact in connection with your membership or application of membership.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership, but the rescission will completely cancel your membership so that no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable premiums, except that we may subtract any amounts you owe us.

Subscribers

You are a Subscriber if you are the person who applied and was accepted for Health Plan membership and agreed to be responsible for payment. In the event the applicant is a minor or is incompetent, the parent or guardian is the responsible party for the account. Under single coverage, only the Subscriber is covered.

Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents, if they were enrolled as dependents under your previous plan and meet the definition of a Federally Eligible Individual.

- Your Spouse.
- Your or your Spouse's children (including adopted children or children placed with you for adoption) who are under age 28.
- Other dependent persons (but not including foster children) who meet all of the following requirements:
 - They are under age 28 and;
 - You or your Spouse is the court-appointed guardian (or was before the person reached age 18).

Continuation of Coverage

Persons who meet the Dependent eligibility requirements except for the limiting age may be eligible to continue coverage 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 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.

Note: You must notify us if your Dependent(s) meets this continuation of coverage provision 31 days before the Dependent's 28th birthday.

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. However, coverage is limited to Services rendered on or after your effective date and time.

Special Enrollment Due to Newly Acquired Dependents

Existing Subscribers may add newly eligible Dependents, by submitting a Health Plan-approved Enrollment/Change Form to us within 31 days after a Dependent becomes newly eligible.

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 benefit rules, but must be enrolled within 31 days after birth and an additional premium may be due for membership to continue.

2011 HIPAA Basic Plan Evidence of Coverage

- 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, who are Federally Eligible Individuals and meet all of the other eligibility requirements, the first of the month following the date the Enrollment/Change Form is received 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.

Note: All other family dependents (such as a new Spouse) may apply for membership in one of our other plans. They must meet our current requirements for the plan before they can be enrolled as Members. You may obtain more information from Customer Relations.

Payment of Premium

Premiums are due monthly and must be paid in advance. You must pay the correct amount before the first of each month in order to have coverage for that month. If you do not pay on time, we will send you a notice that you are in default. If you do not respond by paying your premium in full, we will terminate your membership and the membership of all enrolled Dependents. All rights to benefits will cease on your date of termination. The effective date of termination is determined by the last month in which premium was applied. Only Members for whom we have received the correct premiums are entitled to benefits under this Agreement.

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 can be found in the Provider Directory.

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 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 terminate 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 Primary Care Plan Physician, you will be responsible for paying full charges for the care you receive from the new physician. Call us at (216) 524-5001 or 1-877-524-5001 ((216) 389-3187 or 1-877-389-3187 – TTY for the hearing/speech impaired) to change your PCP. 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 1-800-524-5377 (1-877-676-6677 -TTY for the hearing/speech impaired) and an appointment will be arranged for you.

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 to 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 co-insurance) 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 Deductibles 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.

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 or (1-877-398-3187 – TTY for the hearing/speech impaired). If you have selected an Affiliated Physician as your PCP, call that office for assistance.

Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

If you visit a different Kaiser Foundation Health Plan or allied plan service area 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.

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 facilities located in other service areas, call Customer Relations at (216) 621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

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, visits or day limits are calculated on a calendar year basis.

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 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.
- Referral to specialists.
- Recommendations for follow-up care.
- Surgical Procedures.
- Durable Medical Equipment.

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

2011 HIPAA Basic Plan Evidence of Coverage

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 a description of Basic Health Care Services covered under this EOC. Basic Health Care Services are defined as the following Services when Medically Necessary:

- Plan Physician 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 childcare.
- Routine Patient Care for patients enrolled in an Eligible Cancer Clinical Trial as described under the “Definitions” section of this EOC.

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
- The administration of blood and blood products (whole blood, packed red cells, cryoprecipitates, platelets, plasma and fresh frozen plasma).
- Medical Social Services.
- Outpatient surgery (Services performed in a hospital or ambulatory surgical center).
- Obstetrical Department prenatal and postnatal visits.
- Drugs that require administration or observation by medical personnel.

Services listed on our “Preventive Care Services Covered with No Copayments, Coinsurance, or Deductible requirements” list - no charge not subject to the deductible.

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 section, must be arranged and approved by your Plan Physician prior to your admission. Inpatient hospital care for conditions other than Other Mental Health Illnesses is provided with no limitation on covered days.

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:

- 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.

2011 HIPAA Basic Plan Evidence of Coverage

- The administration of blood and blood products (whole blood, packed red cells, cryoprecipitates, platelets, plasma and fresh frozen plasma).
- 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, at their option, who undergo a covered mastectomy, may have this procedure performed 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. Follow-up visits 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 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 “Benefit” section:

- Ambulance.
- Dialysis.
- Drugs and Supplies.
- Durable Medical Equipment (DME), External Prosthetics and Orthotics.
- Emergency Services.
- Family Planning.
- Hearing.
- Infertility Services.
- Laboratory, X-ray, and Other Diagnostic Services.
- Mental Health Services.
- Preventive Exams and Services.
- Prosthetic Devices (Internally Implanted).
- Reconstructive Surgery.
- Transplant Services.
- Urgent Care Services.

Ambulance

Ambulance Service (including licensed air ambulance) is only covered in conjunction with a covered Emergency Service incurred within or outside the Service Area. We will not cover ambulance Services in any other circumstance, even if no other transportation is available. For a description of an emergency, see “Emergency Services” defined later in this 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.

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 and;
- You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis and;
- The facility is certified by Medicare and;
- 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

Administered Drugs

The following drugs and supplies are covered during an approved inpatient stay in a Plan Hospital. They are also covered if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office, emergency facility, or urgent care facility.

- All prescribed drugs.
- Injectables.
- Radioactive materials used for therapeutic purposes.
- Vaccines and immunizations approved for use by the Food and Drug Administration (FDA) and which are medically indicated and consistent with accepted medical practice.
- Allergy test and treatment materials.

Drugs purchased by members

Outpatient prescription and non prescription drugs purchased by Members are not covered.

Durable Medical Equipment (DME), External Prosthetics & 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 on our DME formulary. In order to have coverage, you must meet our Health Plan criteria for use of any equipment. Durable medical equipment for a six month period is covered for use in your home when prescribed by a Plan Physician and obtained from a provider designated by us. Coverage is limited to rental or purchase (whichever is less) of 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. 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 during the six month period.

An external 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 months in cases of covered bilateral mastectomy). Members pay 40% of Eligible Charges for external breast prostheses. 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 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 may be covered.

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 and have selected a Medical Group Physician as your PCP, call our 24-hour Care Line for assistance at 1-800-524-7377 or (1-800-398-3187 - TTY for the hearing/speech impaired). If you have selected an Affiliated Physician as your PCP, call that office for assistance. Refer to the Provider Directory for the emergency number of your physician's office. To better coordinate your emergency care, if you are inside the Service Area, you should go to a Plan Facility if possible.

2011 HIPAA Basic Plan Evidence of Coverage

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, within 24 hours 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.

Payment will be limited to Emergency Services required before your medical condition permits your travel or transfer to a Plan Facility. Continuing or follow-up care from non-Plan providers is not covered. 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: The Emergency Services Copayment, if any, is waived when you are admitted as an inpatient directly to the hospital 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 the Emergency Services Copayment will not be waived.

Family Planning

We cover family planning counseling, including abortion counseling, information on birth control, tubal ligations, and vasectomies. See the section titled: “Laboratory, X-ray, and Other Diagnostic Services” for information regarding those Services.

Hearing

We cover medical Services necessary for the diagnosis and treatment of illness or injury to the ear.

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 generally 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).

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

- Donor semen or eggs, and Services related to their procurement and storage 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.

Refer to “Surrogacy Arrangements” in the Reductions section of this EOC for additional information.

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.

Services listed on our “Preventive Care Services Covered With No Copayments, Coinsurance, or Deductible requirements list” no charge, not subject to the deductible

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.

No Other Mental health Illnesses, other than those described in this “Mental Health Services” section are covered under this plan.

Preventive Care 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/Limitations/Reductions” section.

We cover the preventive care Services listed on our “Preventive Care Services Covered With No Copayments” list at no charge. Depending on your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling

2011 HIPAA Basic Plan Evidence of Coverage

- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21

Eligible services 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.

Preventive Services may change according to federal guidelines and will be in effect as of January 1 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.

We also cover additional mandated preventive benefits at the Copayment and/or Deductible listed in the Copayment chart in the back of this Evidence of Coverage.

Should you receive covered preventive or 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.

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 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.

Screening sigmoidoscopies or colonoscopies resulting in biopsies, polyp removal or other diagnostic/therapeutic procedures are not Covered Services under this Preventative Exams and Services heading but are Covered Services under the Outpatient Care heading in this General Benefits section and may affect your out of pocket cost.

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. Members pay 40% of Eligible Charges for internally implanted prosthetic devices. The devices must be approved for general use by the FDA.

Reconstructive Surgery

We cover Inpatient and Outpatient Services for reconstructive surgery 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,
- Will correct disfigurement resulting from a mastectomy. Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast 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.”

Transplant Services

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

- Transplants for heart, heart-lung, lung, liver, and pancreas are reviewed by the Ohio Transplant Consortium and;
- 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:

- Transplants for heart, heart-lung, lung, liver, pancreas, bowel, kidney, cornea, and bone marrow.
- Inpatient Services as described under “Hospital Inpatient Care.”
- Outpatient Services as described under “Outpatient Care.”

2011 HIPAA Basic Plan Evidence of Coverage

- 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.

Limitations and Exclusions:

- We do not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.
- 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 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 Web site kp.org. 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.

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.

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**:

1. All dental, dental related Services, or dental related Services applied to TMJ (temporomandibular joint disorder) are not covered.
2. Except as stated in the "Benefits" section, cosmetic surgery, breast augmentation and reduction surgery, penile implants, and all related Services and supplies are not covered, unless Medically Necessary.
3. Treatment of obesity, including diet substitutes and supplements is not covered
4. Experimental or investigational procedures, supplies, and drugs are not covered except for Routine Patient Care associated with cancer clinical trials as described under the "Definitions" section.. Routine Patient Care associated with an "Eligible Cancer Clinical Trial" is covered.
5. 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:
 - a) A Service, item or drug that is the subject of the cancer clinical trial; or,
 - b) 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,
 - c) An investigational or experimental drug or device that has not been approved for market by the FDA; or,
 - d) 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,
 - e) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or,

2011 HIPAA Basic Plan Evidence of Coverage

- f) 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.
6. All Services that are not Medically Necessary, except for required preventive Services are not covered.
7. Recreational, sexual, or education therapy is not covered. Speech therapy, physical therapy, and occupational therapy are covered on an inpatient basis only.
8. Foot care is not covered when performed to:
 - Treat weak, strained or flat feet or instability or imbalance of the foot; or,
 - Treat corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness.
9. Vision care benefits, orthoptics (eye training), low vision aids, or any related type of Service, including eyeglasses and contact lenses are not covered.
10. Services rendered prior to your effective date of coverage or after your coverage terminates are not covered (unless stated otherwise regarding termination of coverage).
11. Services received from a member of the immediate family or rendered by a physician or another provider to himself or herself are not covered.
12. Services that are for any illness or injury occurring in the course of employment if whole or partial compensation is available under Worker's Compensation laws or laws of any governmental entity are not covered.
13. Any Service for which the Member has no legal obligation to pay in the absence of this or similar coverage is not covered.
14. Services and expenses related to all aspects of organ or tissue procurement rendered or incurred prior to the site of presentation to the donee, including all donor expenses are not covered.
15. Transportation and living expenses are not covered, except for emergency ambulance Services and organ transplants performed outside of the Service Area.
16. Services are not covered when received while incarcerated or in the custody of law enforcement officials when such is the financial responsibility of the applicable prison system.
17. Services of non-Plan providers are not covered, except in an emergency or for out-of-area benefits, or when authorized in advance in writing by Health Plan.
18. Services and treatment of mental retardation and other mental health Services are not covered, except as otherwise provided.
19. Hearing aids and related Services and supplies are not covered, except medical Services required for diagnosis and treatment of diseases of, or injury to, the ears.
20. Except as stated in the "Benefits" section, reconstructive surgery is not covered, unless deemed Medically Necessary by a Plan Provider with the prior approval of Health Plan to restore normal physiological functioning.
21. Outpatient private duty nursing or private room for hospitalization is not covered.
22. Nonprescription drugs, infertility drugs, growth hormones, medications and contraceptive devices, birth control pills, including, but not limited to, Norplant and similar products are not covered.
23. Personal comfort items (such as radio, television, telephone, and guest meals) and private rooms are not covered, unless Medically Necessary during inpatient hospitalization.
24. Custodial or domiciliary care, or convalescent care, skilled nursing care, hospice care or home health care is not covered.
25. Physical therapy and rehabilitation Services are not covered.
26. Reversals of voluntary induced infertility, experimental infertility procedures, and non-Medically Necessary procedures including but not limited to artificial insemination, procedures related to pre-implantation genetic diagnosis prior to in vitro fertilization, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) are not covered.
27. Procedures, Services, and supplies related to sex transformations are not covered.
28. Services on which claim is based from care which is received in a veteran, marine, or other federal hospital are not covered.
29. Nonmedical ancillary Services and long-term rehabilitative Services are not covered for the treatment of alcoholism or drug abuse, including rehabilitation Services in a specialized inpatient or residential facility.
30. Except as stated in the "Benefits" section, orthotic, and prosthetic devices are not covered.
31. Autologous bone marrow transplants, in some instances, are not covered.
32. Services of chiropractors, podiatrists, and optometrists are not covered.
33. Blood or blood plasma is not covered, unless listed as covered in the "Benefits" section.
34. Kidney dialysis and end stage renal disease treatment is not covered after Medicare assumes responsibility.
35. Elective abortions are not covered.
36. Experimental artificial organs and related procedures are not covered.
37. Elective pre-surgery testing on an inpatient basis is not covered without the pre-certification of Health Plan.
38. Megavitamin therapy, psychosurgery, and nutritional based therapy are not covered.

2011 HIPAA Basic Plan Evidence of Coverage

39. Salabrasion, chemosurgery, or other such skin abrasion procedures to remove scars, tattoos, or which are performed as treatment for acne are not covered.
40. Services performed after Health Plan or the Plan Provider has advised the Member that further Services are not medically appropriate or not covered are not covered.
41. Except for Emergency Services and Referral Services, Services, and supplies not provided, arranged or authorized by a Plan Physician are not covered.
42. Alternative medical Services including acupuncture, naturopathy, and massage therapy are not covered.
43. Cardiac rehabilitation is not covered.
44. 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, 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.
45. 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.
46. Hypnotherapy and hypnotic anesthesia are not covered.
47. Services to patients who are seeking Services for other than therapeutic purposes or who are not responsive to therapeutic management are not covered.
48. Testing for ability, aptitude, intelligence or interest is not covered.
49. 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.
50. Services provided by a Residential Treatment Center are not covered. This includes specialized behavioral programs in a residential facility for eating disorders.
51. Physical examinations or other Services (a) required for obtaining or maintaining employment, or participation in employee programs, or (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.
52. 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.

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 Physicians 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.

2011 HIPAA Basic Plan Evidence of Coverage

- 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:

- 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.
- (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

2011 HIPAA Basic Plan Evidence of Coverage

(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 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 any 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).

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

Claims and Internal Appeals - Health Plan will review claims and appeals that you make for Services or payment, and we may use medical experts to help us review claims and appeals.

A **claim**, as used in this section, is a request for us to provide a Service or pay for a Service that you have already received. You or your health care provider may make a claim. Depending on your situation, your physician or other health care provider may ask us whether we will authorize or pay for a Service for you. If you want to make a claim, you may follow the procedures described below.

An **appeal** is a request for a reconsideration of our decision when we (a) have decided not to provide or pay for all or part of a Service in your claim or (b) terminated your membership retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage; for example, rescission for fraud or intentional misrepresentation by you (or a person seeking coverage on your behalf) or your employer. Continuation of coverage will be provided pending the outcome of appeal when the appeal is associated with an ongoing course of treatment or (c) denied your membership application.

You or someone you appoint can make an appeal. If you would like to appoint someone to act as your authorized representative to make an appeal for you, you must provide us with a signed, dated statement telling us whom you authorize to act on your behalf. To obtain a form to appoint someone to act on your behalf, please call Customer Relations at (216) 621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired) or obtain the form at a Plan Facility.

You may review our claim file and give us evidence and testimony. If we intend to uphold our previous adverse benefit determination in whole or in part, then before we send you a final decision, we will provide you with any additional evidence we are considering, relying on, or generating in making our decision, and any new or additional rationale on which our decision may be based.

We do not charge you for claims or appeals, but you must bear the cost of anyone you hire to represent or help you. If you miss a deadline for making a claim or appeal, we may decline to review it.

There are several types of claims and appeals, each of which has a different procedure described below:

- Pre-Service Claims and Appeals (Urgent & Non-Urgent)
- Concurrent Care Claims and Appeals

- **Post-Service Claims and Appeals**
- **Pre-Service Claims and Appeals.** Pre-service claims are requests that Health Plan provide or pay for a Service that you have not yet received. We will decide whether your claim or appeal is urgent or non-urgent. A claim or 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 could not be adequately managed without the Services you are requesting. 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 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

NON-URGENT CLAIM - Procedure for making a non-urgent pre-service claim.

1. Tell us that you want to make a claim for Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may call 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.
2. We will review your claim, and if we have all the information we need we will make a decision within two business days. We will notify you and your provider via phone, fax or in writing with our decision within three business days of making our decision. If we tell you we need more time and ask you for more information, we will ask you for the information within two business days of receipt of your request. We will make a decision within two business days of receiving 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 our request, we will make a decision based on the information we have within two business days and notify you and your provider of our decision via phone, fax or in writing within three business days after making the decision.
3. If we deny your claim (if we do not agree to provide or pay for all the Services you requested), we will notify you of our decision in writing and we will tell you why we denied your claim and how you can appeal.

NON-URGENT APPEAL - Procedure for appealing our denial of a non-urgent pre-service claim.

1. Within 180 days after you receive our written decision denying your claim, you or your authorized representative must tell us that you want to appeal our denial of your claim for Health Plan to provide or pay for a Service you have not yet received. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your written request and the supporting documents constitute your appeal. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371 – TTY for the hearing/speech impaired), or mail a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.
2. We will review your appeal and send you a written decision within 30 days after we receive your appeal.
3. If we deny your appeal, our written decision will tell you why we denied your appeal and will include further options that may be available to you.

URGENT CLAIM - Procedure for making an urgent pre-service claim.

1. Tell us that you want to make an urgent claim for Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may call 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.
2. If we determine that your claim is not urgent, we may treat your claim as non-urgent.

2011 HIPAA Basic Plan Evidence of Coverage

3. We will review your claim, and if we have all the information we need we will notify you of our decision orally or in writing within a time frame appropriate to your clinical condition but not more than 24 hours after we receive your claim. If we notify you orally, we will send you written confirmation of our decision within three calendar days after that. Within 24 hours after we receive your claim, we may ask you for more information. If we do not receive the requested information (including documents) within 48 hours after our request, we will notify you of our decision orally or in writing within 48 hours after that. If we notify you orally, we will send you written confirmation of our decision within three calendar days after that.
4. If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our written decision will tell you why we denied your claim and how you can appeal.

URGENT APPEAL - Procedure for appealing our denial of an urgent pre-service claim

1. You or your authorized representative must tell us that you want to appeal our denial of your urgent claim for Health Plan to provide or pay for a Service you have not yet received. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your written or oral request and the supporting documents constitute your appeal. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371 – TTY for the hearing/speech impaired), or mail a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.
2. If we determine that your appeal is not urgent, we may treat your appeal as non-urgent.
3. We will review your appeal and notify you of our decision orally or in writing as expeditiously as your clinical condition requires, but no more than 72 hours after we receive your appeal request. If we notify you orally, we will send you a written confirmation of our decision within three calendar days after that.
4. If we deny your appeal, our written decision will tell you why we denied your appeal and will include further options that may be available to you.

- **Concurrent Care Claims and Appeals.** Concurrent care claims are requests that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either (a) the course of treatment your physician prescribed will expire, or (b) your physician decides to shorten the course of treatment. If you have any general questions about concurrent care claims or appeals, please call Customer Relations at (216) 621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

CLAIM - Procedure for making a concurrent care claim when your course of treatment will expire.

1. At least 24 hours before the expiration of the course of treatment, tell us that you want to make a concurrent care claim for Health Plan to continue to approve the course of treatment that is expiring. Your written or oral request and any related documents you give us constitute your claim. You may call 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.
2. We will review your claim and notify you of our decision orally or in writing within 24 hours after we receive your claim. If we notify you orally, we will send you a written confirmation of our decision within three calendar days after we receive your claim.
3. If we deny your claim (if we do not agree to continue approval of all the Services you requested), our written decision will tell you why we denied your claim and how you can appeal.

APPEAL - Procedure for appealing our denial of a concurrent care claim when your course of treatment will expire.

1. You or your authorized representative must tell us that you want to appeal our denial of your concurrent care claim for Health Plan to continue to approve a course of treatment that is expiring. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your written or oral request and the supporting documents constitute your appeal. If we do not receive your appeal within 48 hours after you receive our written decision denying your claim, we may treat your appeal as non-urgent. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371 - TTY for

2011 HIPAA Basic Plan Evidence of Coverage

the hearing/speech impaired), or mail or a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.

2. We will review your appeal and notify you of our decision orally or in writing within 72 hours after we receive your appeal. If we notify you orally, we will send you a written decision within three calendar days after that.
3. If we deny your appeal, our written decision will tell you why we denied your appeal and will include further options that may be available to you.

APPEAL - Procedure for appealing your physician's decision to shorten your course of treatment.

1. If you receive a written decision from Health Plan that says that your physician has decided to shorten your course of treatment, you or your authorized representative must tell us that you want to appeal the decision. Explain all of the reasons why you disagree with your physician's decision to shorten your course of treatment, and include all supporting documents. Your written or oral request and the supporting documents constitute your appeal. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371 - TTY for the hearing/speech impaired), or mail or a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.
2. We will review your appeal and notify you of our decision orally or in writing within 72 hours after we receive your appeal. If we notify you orally, we will send you a written decision within three calendar days after that.
3. If we deny your appeal, our written decision will tell you why we denied your appeal and will include further options that may be available to you.

- **Post-Service Claims and Appeals** Post-service claims are requests for payment for Services you already received, including claims for Out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call Customer Relations at (216) 621-7100 or 1-800-686-7100 (1-877-676-6677 - TTY for the hearing/speech impaired).

CLAIM - Procedure for making a post-service claim.

1. Within one year from the date of Service, mail us a letter explaining the Services, the date you received them, where you received them, who provided them, and why you think we should pay for them. Include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. Mail your claim to: Kaiser Permanente, P.O. Box 5316, Cleveland, Ohio 44101-9774. Claims received from you or the health care provider after one year from the date of Service will not be accepted.
2. We will review your claim, and if we have all the information we need we will send you a written decision within 30 calendar days after we receive your claim. If we tell you we need more time and ask you for more information, we will send you a written 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 our request, we will make a decision based on the information we have and send you a written decision within 15 days after the end of the 45 days.
3. If we deny your claim (if we do not pay for all the Services you requested), our written decision will tell you why we denied your claim and how you can appeal.

APPEAL - Procedure for appealing our denial of a post-service claim.

1. Within 180 days after you receive our written decision denying your claim, you or your authorized representative must tell us that you want to appeal our denial of your claim for Health Plan to pay for a Service you already received. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your written request and the supporting documents constitute your appeal. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371-TTY for the hearing/speech impaired), or mail a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.

2011 HIPAA Basic Plan Evidence of Coverage

2. We will review your appeal and send you a written decision within 60 days after we receive your appeal.
3. If we deny your appeal, our written decision will tell you why we denied your appeal and will include further options that may be available to you.

You have the right to access the Ohio external review process if we fail to adhere to this appeals process. You may also submit an appeal to us and at the same time, access the Ohio external review process for an expedited review of claims involving urgent care or an ongoing course of treatment. For more information about how to obtain this review, please call the Appeals Unit at (216) 635-4664.

External Appeals. After you have exhausted the internal appeal process, and the plan continues to deny the Service you may request a review from another source. The Appeals Unit will inform you in writing of your right to this review. The Appeals Unit will facilitate the external review process by arranging the evaluation, forwarding pertinent information, and communicating with you. You may appeal denials for any reason listed below:

- **Decisions Made Because Services Are Not Covered.** The Superintendent of the Ohio Department of Insurance “the Superintendent” has established and is maintaining a system for receiving and reviewing written requests by a Covered Person who has been denied coverage of a health care service because the Plan has determined that the health care service is not covered under the terms of the Policy. Covered Persons or their Authorized Representative may request a review of the Plan’s decision from the Ohio Department of Insurance and may direct further correspondence to:

The State of Ohio Department of Insurance
50 W. Town Street, Third Floor – Suite 300
Columbus, Ohio 43215
Attn: Consumer Services Division
1-800-686-1526 or (614) 644-2673
<http://insurance.ohio.gov>

The Superintendent will notify the Covered Person or Authorized Representative and the Plan of its determination or of its inability to make a determination because such determination requires the resolution of a medical issue.

If the Superintendent notifies the Plan that the determination requires the resolution of a medical issue, the Plan will initiate an external review to an independent review organization IRO automatically, without a request from the Covered Person or Authorized Representative. If the Superintendent notifies the Plan that the health care service is not a Covered Expense, the Plan is not required to cover the service nor to allow the Covered Person the opportunity for an external review. If the Superintendent determines that the Service is a covered benefit, the Plan must pay for the Service.

- **Decisions Made Because Services Are Not Medically Necessary.** When the denial is based on medical necessity, the Appeals Unit will inform you or your Authorized Representative of the right to request an external, independent review. Should you wish to pursue such a review, you must contact the Appeals Unit within 180 days of the notice. You will need to specify whether you are requesting a standard or expedited appeal. For standard appeals, you must also submit certification from the provider that the cost of the denied Service(s) is at least \$500.00. The IRO will review your medical records and determine if the recommended Service is Medically Necessary. If the IRO determines that the Service is Medically Necessary, the Plan must pay for the Service according to the terms of this Evidence of Coverage. If the IRO determines that the Service is not Medically Necessary, the Plan does not have to pay for the Service.
- **Decisions Made Because Services Are Experimental.** Should your request involve a determination that the care represents an experimental or investigational Service, you must meet the following criteria before you may proceed to external review:
 1. You have a terminal condition that, according to the current diagnosis made by your PCP, there is a high probability of causing death within two years.
 2. You must request an external review not later than 180 days after receipt of the results of internal review.
 3. Your PCP certifies that you have the condition described in number (1) above and any of the following situations are applicable.

2011 HIPAA Basic Plan Evidence of Coverage

- Standard therapies have not been effective in improving your condition; or,
 - Standard therapies are not medically appropriate for you; or,
 - There is no standard therapy covered by us that will benefit you more than the therapy requested by either you or your PCP.
4. Your PCP has recommended a drug, device, procedure or therapy that he/she certifies in writing is likely to be more beneficial than standard therapies or you have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
 5. You have exhausted all internal appeals.
 6. The drug, device, procedure or other therapy for which coverage has been denied would be a covered benefit if it were not considered experimental or investigational.

The standard timeframe for response from the IRO is 30 days. Expedited requests must be answered within seven days. We are bound by the decisions made by the IRO and, when favorable, will provide or pay for the Service. Health Plan will also pay the fees associated with this external review process.

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
PO 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/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.

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.

Termination by Member

You may terminate membership for yourself or any Dependent(s), by giving us advance written notice. Your membership will be terminated the first of the month following receipt of your written request for termination. If we do not receive your request for termination in writing and your membership is terminated by us for nonpayment or cause, any future enrollments with Kaiser Permanente may be jeopardized.

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 that Premiums are paid, or upon 30 days written notice, whichever is sooner.

Note: Dependents who have lost dependency status or no longer meet the eligibility requirements under this plan may be eligible to apply as a Subscriber under this plan, the Conversion plan, or other plans offered by Kaiser Permanente. See

“Conversion of Membership” later in this section for more information on the loss of eligibility as a Dependent.

Termination for Fraud or Intentional Misrepresentation

We may terminate 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; or,
- 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 terminate 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 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. You may not be allowed to re-enroll in the Health Plan.

Misrepresentation on Application

This agreement is void if facts were not disclosed or were misrepresented on the enrollment application which would have resulted in Health Plan declining coverage if the facts had been fully and accurately disclosed. Health Plan has the right to bill you for costs of providing or arranging care for Services that are not covered under this agreement.

Termination for Nonpayment

Nonpayment of Premium

You are entitled to coverage only for the period for which we have received the appropriate Premiums from you. If you fail to pay us the appropriate Premiums for you and/or your Family Unit, we may terminate the memberships of everyone in your Family Unit. Any future enrollment in Kaiser Permanente may be jeopardized.

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

You must notify us immediately if you move to another Kaiser Foundation Health Plan or allied plan service area. If you move to another Kaiser Foundation Plan or allied plan service area, you will not be able to transfer membership and your membership under this EOC will terminate. You may contact the Kaiser Foundation Health Plan in the new area for information on plans available there.

Termination for Movement Outside the Service Area

If you permanently move outside of the Health Plan Service Area or are away from the Service Area for more than 90 days after you are 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.

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 you 90 days prior written notice. If we discontinue offering all products in a market, we will give you 180 days prior written notice.

Continuation of Coverage for Reservists

If you are a reservist and you report for active duty outside of the Service Area for more than 90 days, we will not automatically terminate your membership or the membership of your enrolled Dependents. During such active duty, you may: (1) Continue coverage and timely payment of Premiums for yourself and/or your enrolled Dependents; or (2) Suspend coverage for yourself during active duty and resume coverage without medical screening upon discharge from active duty. No Premium payment is due for any period of suspended coverage under this section.

Benefits under any military health plan supersede coverage under this plan. All other Plan provisions apply. To notify us of your election and to provide proof of active duty status and discharge from active duty status, you must call Customer Relations at (216) 621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Conversion of Membership

A Dependent who becomes divorced from a Subscriber, a Dependent of a Subscriber who has died or any other Dependent who:

- Has reached the end of the month in which he or she turns 28; or,
- Has reached the end of the month in which he or she no longer meets all of the other requirements of this Agreement for dependency status,

A Dependent(s) may become a Subscriber under this EOC without reapplication and without any interruption in coverage by notifying us in writing within 31 days of the event. Dependents who become Subscribers under this plan become responsible for all applicable Premiums, Deductibles, and Copayments.

However, Dependents may not become Subscribers under this EOC if (1) they are eligible for government sponsored coverage, including Medicaid or Medicare, that is at least comparable to the benefits under this EOC, (2) we terminate your membership under “Termination for Cause” or “Termination for Nonpayment” described in this section, or (3) they are eligible for group coverage through an employer or association and the group coverage provides benefits comparable to the benefits under a direct payment plan.

A Dependent who loses eligibility may also apply for one of the other plans offered by Kaiser Permanente. The applicant will need to meet all of the eligibility requirements of the plan.

For information about converting membership or about applying for coverage under another direct payment plan, 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 this Agreement and 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 for , 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.

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 and individual market can apply a preexisting condition exclusion. We will send a certificate to you and your eligible Family Dependents when your coverage 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 provision of 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, Deductibles 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.

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 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
PO 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 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.

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 Web site at kp.org.

Refunds Due Members

Upon termination pending claims for reimbursement for Services received while you were a Member will be paid to you minus any amount you owe us.

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, Copayment 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

2011 HIPAA Basic Plan Evidence of Coverage

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 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 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.

2011 HIPAA Basic Plan Evidence of Coverage

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, 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.

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 list 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 you.

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.

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, and 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: You are a Subscriber if you are the person who applied and was accepted for Health Plan membership and agreed to be responsible for payment. In the event the applicant is incompetent, the parent or guardian is the responsible party for the account.

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, 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 question 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).

Deductible, Copayments, and Out-of-Pocket Maximum

This section discusses:

- The Deductibles and Copayments you are responsible for paying.
- Benefit maximums including dollar, visit or time period maximums.
- Out-of-Pocket Maximum.

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.

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 the calendar year.

2011 HIPAA Basic Plan Evidence of Coverage

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 Deductible 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. After the Deductible is satisfied, you pay the applicable Copayment for the 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. We recommend that you also keep your receipts for Services received. See the Copayment chart for your plan Deductible and for the Services subject to the Deductible.

Copayments

Copayments are due at the time of your visit. Copayments calculated on a percentage are based on 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 Service will not exceed 40% of the average cost of the Service. The average cost of a Service is calculated by dividing Eligible Charges by the total number of 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 contract year for certain Services covered under this EOC. 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 contract year for Services for which Copayments are applied toward the Out-of-Pocket Maximum. The limits are listed in the Copayment chart. Copayments for only the following covered Services apply toward these limits:

- Inpatient and outpatient hospital care.
- Laboratory and x-ray.
- Ambulance Services.
- Emergency Services.
- Urgent Care Services.
- Professional Services for Basic Health Care Services.

We recommend that you keep your receipts for Services received. See the Copayment chart on the next page.

2011 HIPAA Basic Plan Evidence of Coverage

BENEFIT:	YOU PAY
Outpatient Care*	
Primary Care office visits	\$25 per visit
Specialty Care office visits	\$40 per visit
Chemotherapy, Radiation therapy, Respiratory therapy, Outpatient surgery in a hospital or ambulatory surgical center	40% after Deductible
Hospital Inpatient Care*	40% after Deductible (no limit on covered days)
Ambulance*	\$110 per trip
Dialysis*	40% after Deductible
Drugs and Supplies	
Administered Drugs*	40% after Deductible
Durable Medical Equipment (DME), External Prosthetics & Orthotics (items listed in "Benefits" section only)	40% after Deductible
Emergency Services*	
Emergency Services at a Plan Facility	\$110 per visit; waived if admitted
Emergency Services at a non-Plan facility	\$110 per visit; waived if admitted
Family Planning*	\$40 per visit
Hearing	\$40 per visit
Infertility Services*	
Inpatient	40% after Deductible
Outpatient	\$40 per visit
Laboratory, X-Ray, And Other Diagnostic Services*	40% after Deductible
Mental Health Services	
Biologically Based Mental Illnesses*	
Inpatient	40% after Deductible (no limit on covered days)
Outpatient Individual Therapy	\$40 per visit
Outpatient Group Therapy	\$20 per visit
Other Mental Health Illnesses	Not Covered
Preventive Exams and Services*	
Well-child care exams for children through age 21	Nothing
Preventive exams performed by a PCP	Nothing
Preventive exams performed by a specialist	Nothing
Flexible Sigmoidoscopy and Screening Colonoscopy	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
Prosthetic Devices (Internally Implanted)	40% after Deductible
Reconstructive Surgery*	
Inpatient	40% after Deductible
Outpatient	\$40 per visit
Transplant Services*	
Inpatient	40% after Deductible
Outpatient	\$40 per visit
Urgent Care Services *	
In a Plan urgent care facility within the Service Area or any urgent care facility outside the Service Area.	\$45 per visit
Annual Deductible	
Single	\$1,000

2011 HIPAA Basic Plan Evidence of Coverage

BENEFIT:	YOU PAY
Family	\$2,000
Annual Out-of-Pocket Maximum	
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 Services paid by Kaiser Permanente.