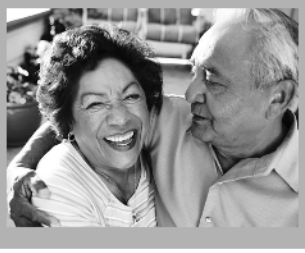


# guide to
## YOUR BENEFITS AND SERVICES

kaiserpermanente.org

# Your 2008

Group Plan
Evidence of Coverage

Excellent NCQA Accreditation
-for HMO and Medicare plans

KAISER PERMANENTE®
Georgia Region

BOOK 27

## *Welcome to Kaiser Permanente!*

We are pleased that you have selected us as your health care provider. At Kaiser Permanente, we are committed to taking care of your needs and pledge to keep our focus on what's most important . . . your overall health.

Health is all about feeling good, in every way. Health is more than trying not to get sick – and getting care when you do. It is taking care of ourselves. Staying balanced – physically, mentally, and emotionally. Knowing how to do it. Making good choices. You might be surprised to hear that from a health care company.

At Kaiser Permanente, we understand the need to care for the whole you. We want to help you take an active role in your own health so that you can live your life to the fullest. So you can thrive.

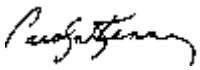
Please take a few minutes to get to know us by reviewing this Evidence of Coverage (EOC). Your EOC is customized to inform you of what services are specifically available to you and what your out-of-pocket expenses will be. Please refer to the "Schedule of Benefits" section at the back of this EOC for a summary of applicable charges. Your I.D. card(s), Member Handbook, and this EOC give you important information about accessing care at Kaiser Permanente. Your I.D. card(s) and Member Handbook will be mailed to you separately.

With Kaiser Permanente, we want to help keep you healthy and enjoying life. That's why we offer preventive care for every stage of your life, from routine physicals to other screenings to help detect health problems before they become serious. If you have questions about your Kaiser Permanente benefits or accessing care, please call our Customer Service Department for assistance, Monday through Friday from 8:30 a.m. to 9 p.m., and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590. When you are ready to schedule an appointment, please call our appointment center at (404) 365-0966.

Your path to good health may take you many places: your doctor's office, a fitness class, a health food store, maybe even a bike trail near your home. Ultimately, the path leads to a healthier, happier you.

Once again, welcome!

Sincerely,



Carolyn Kenny

President

# Table Of Contents

# Introduction

## About this Evidence of Coverage (EOC) for Group Subscribers

This Evidence of Coverage (EOC) describes Kaiser Permanente's HMO Plan. It is issued as part of and incorporated by reference into the Group Agreement between Kaiser Foundation Health Plan of Georgia, Inc. and your Group. For benefits provided under any other Health Plan program, refer to that plan's EOC.

This EOC includes a description of the benefits and Services available to you as a Member enrolled in Kaiser Permanente's HMO Plan. 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.

We may modify this EOC in the future, subject to Department of Insurance approval. If we do, we will notify your Group in writing before the changes are effective. If your Group continues to pay Premium or accepts benefits after the changes have gone into effect, they thereby agree to the changes. This consent also covers you and your enrolled Dependents.

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

Certain Services require authorization by Medical Group or its designee, as described in this EOC.

This EOC tells you how your benefits are provided.

## About Kaiser Permanente's HMO Plan

You have selected the Kaiser Permanente HMO Plan.

Kaiser Foundation Health Plan of Georgia, Inc. is a nonprofit health care service plan. We arrange medical care for Members on a pre-paid basis.

We provide health care benefits to Members using Medical Group Physicians and Affiliated Community Physicians, located in our Service Area, which is described in our "Definitions" section. All covered Services must be medically necessary to prevent, diagnose, or treat a medical condition, and must be provided, prescribed or directed by a Medical Group Physician or an Affiliated Community Physician.

A Service or item is medically necessary only if a Medical Group Physician or an Affiliated Community Physician determines that its omission would adversely affect a Member's health.

You must receive your health care Services from Plan Providers within our Service Area, except for:

- Emergency Services, described in the "Benefits" section; and
- Authorized referrals, as described in this EOC; and
- Our Visiting Member Program as described in this EOC.

You may be required to pay Copayments, Annual Deductible(s), any other deductible(s) applicable to the benefit, and Coinsurance for some Services. When you pay a Copayment, Annual Deductible and Coinsurance ask for and keep the receipt. There may be limits to the total amount of Copayments, Coinsurance and deductibles you must pay each Year for certain Services covered under this EOC. Refer to the "Schedule of Benefits" section for more information.

## How to use this EOC

It is important to familiarize yourself with your coverage, by reading this EOC completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please read the sections applicable to you carefully. If you have any questions about your benefits as presented in this EOC, please contact your employer's employee benefit specialist or call our Customer Service Department Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

This EOC is divided into the following sections:

- **"Definitions**" includes defined terms you should know.
- **"Premium, Eligibility, Enrollment and Effective Date**" discusses Premium, who is eligible to enroll, how to enroll, and when your coverage begins.
- **"How to Obtain Services**" explains how to obtain covered Services, types of medical appointments, choosing a personal physician, changing your personal physician, your ID card, and getting care if you visit a service area at another Kaiser Foundation Health Plan.
- **"General Exclusions, Limitations, Reimbursement of Health Plan, and Coordination of Benefits (COB)**" lists general exclusions and limitations that apply to all benefits, and describes our rights if another party is responsible for your medical condition. It also describes the Coordination of Benefit rules if you have coverage through more than one health plan. Exclusions and limitations that apply only to a particular benefit are described in the "Benefits" section.

- **"Getting Assistance, Filing Claims, and Dispute Resolution**" tells you where you can get answers to questions, and explains how to file claims, appeals, and grievances.
- **"Termination of Membership**" describes the circumstances under which your Health Plan membership may end and options available to continue membership.
- **"Miscellaneous Provisions**" contains information relating to the administration of this EOC and other subjects.
- **"Benefits**" describes the medical and hospital Services covered under this EOC.
- **"Schedule of Benefits**" lists a summary of the benefits and the Copayments and/or Coinsurance you must pay for covered Services described in the "Benefits" section. The Schedule includes day and visit limits and Benefit Maximums.
- **"Additional Benefits Purchased by Your Group**" is included only if your Group has purchased additional benefits. This section, if included, describes the additional medical and hospital Services covered under this EOC, that have been purchased by your Group.

## Definitions

Except as otherwise noted, the following terms, when capitalized and used in any part of this EOC, mean:

**Affiliated Community Physician:** Any doctor of medicine or other practitioner contracting with Medical Group to provide covered Services to Members under this EOC and listed as an Affiliated Community Physician in your Physician Directory.

**Annual Deductible:** The amount of Eligible Charges you must pay each Year before we have any obligation to pay any amount for certain covered Services, other than Emergency Services and well-child care visits as described in this EOC. The Annual Deductible is shown in the "Schedule of Benefits" section. The Annual Deductible applies separately to each Member during each Year. If the Family Deductible shown in the Schedule of Benefits is satisfied in any one Year by covered Family Members, then the individual Single Deductible will not be further applied to any other Eligible Charges incurred during the remainder of the Year by any Member in your Family. For Services subject to a deductible, you must pay for the Services when you receive them, until you meet your deductible. After you meet the deductible, you are still obligated to pay the applicable Copayment or Coinsurance for the Services. In some cases, we may agree to bill you, and if we do, we will increase the amount by a $20 service fee and mail you a bill for the entire amount.

The Annual Deductible does not count toward satisfaction of the Out-of-Pocket Maximum(s).

Some covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Benefits. These additional or separate deductibles are not subject to, nor do they count toward the satisfaction of the Annual Deductible, or the Out-of-Pocket Maximum(s).

Annual Deductible Carryover. If you incur Eligible Charges during the last three months of the Year that are applied toward satisfaction of the Annual Deductible for that Year, those charges will also be applied toward your Annual Deductible for the next Year.

Deductible Credit on Takeover. This provision applies if this group coverage replaces your prior group coverage, and your prior group coverage: a) provided similar benefits; and b) was in force within the 90 days immediately preceding the effective date of this group coverage.

Any expenses that were applied to your Annual Deductible under the prior group coverage will be credited toward satisfaction of the Annual Deductible, as applicable under this group coverage, if a) you were covered under your prior group coverage on the day before the effective date of this group coverage; and b) you incurred the expenses during the 90 days before the effective date of this group coverage and those expenses were applied against your prior group coverage deductible; and c) those expenses are recognized as covered under this EOC and subject to a similar deductible provision under this EOC.

**Benefit Maximum**: The total amount of benefits that will be paid by Health Plan for a specified covered Service. Benefit Maximums are shown in the Schedule of Benefits. When a Benefit Maximum is reached, additional expenses you incur for the specific benefit or Services are not covered.

You are responsible for the payment of any amount in excess of the Benefit Maximum.

**Centers for Medicare & Medicaid Services (CMS):** Centers for Medicare & Medicaid Services. This is the federal agency that administers the Medicare program.

**Coinsurance:** The percentage of Eligible Charges that you must pay for certain covered Services as described in the "Schedule of Benefits" section.

**Coinsurance Out-of-Pocket Maximum:** There is a limit to the amount of Coinsurance you or a Family Dependent must pay each Year for covered Services.

For a Member – When your share of incurred Eligible Charges equals the "single" Coinsurance Out-of-Pocket Maximum shown in the Schedule of Benefits during a

Year, we will pay 100% of further Eligible Charges incurred by you for certain covered Services during the remainder of the Year. Specific exceptions are listed below. Keep your receipts to verify the Coinsurance you have paid.

For a Family – When the amount of Eligible Charges incurred by covered Family Members in a Year equals the "Family" Coinsurance Out-of-Pocket Maximum shown in the Schedule of Benefits during a Year, we will pay 100% of further Eligible Charges incurred by you and your covered Family Members for certain covered Services during the remainder of the Year. Specific exceptions are listed below. Keep your receipts to verify the Coinsurance you have paid.

The Coinsurance Out-of-Pocket Maximum is subject to change each Year. See the Schedule of Benefits at the end of this EOC for this Year's Coinsurance Out-of-Pocket Maximum. Any part of a charge that does not qualify as an Eligible Charge, will not be applied toward satisfaction of the Coinsurance Out-of-Pocket Maximum. Copayments, deductibles and charges in excess of the Eligible Charges will not count toward satisfaction of the Coinsurance Out-of-Pocket Maximum.

The Coinsurance Out-of-Pocket Maximum may not apply to all Eligible Charges. Coinsurance for the Services listed below does not apply to your Coinsurance Out-of-Pocket Maximum. Not all Services listed here may be covered under your specific plan. Please refer to the "Schedule of Benefits" section for additional information.

- Services for which you pay a Copayment
- Dental Services
- Hearing Aid
- Infertility treatment Services
- Optical Hardware
- Outpatient Prescription drugs
- Vision Services

NOTE: Some of the Services listed above are covered only when provided by Plan Providers. For more information, refer to the "Schedule of Benefits" section at the end of this EOC.

**Copayment:** The pre-determined dollar amount that you or a Family Dependent must pay for covered Services received from Plan Providers. Copayments are due and payable at the time Services are provided. Copayment amounts are shown in the "Schedule of Benefits" section. Copayments are applied on a per visit or per service basis.

**Copayment Out-of-Pocket Maximum:** There may be a limit to the amount of Copayments you or a Family Dependent must pay each Year for covered Services provided by Plan Providers.

For a Member – When the amount of Copayments you pay equals the "single" Copayment Out-of-Pocket Maximum shown in the Schedule of Benefits during a Year, we will pay 100% of further Eligible Charges incurred by you for certain covered Services during the remainder of the Year. Specific exceptions are listed below. Keep your receipt to verify the Copayments you have paid.

For a Family – When the amount of Copayments incurred by covered Family Members in a Year equals the "Family" Copayment Out-of-Pocket Maximum shown in the Schedule of Benefits section during a Year, we will pay 100% of further Eligible Charges incurred by you and your covered Family Members for certain covered Services during the remainder of the Year. Specific exceptions are listed below. Keep your receipt to verify the Copayments you have paid.

The Copayment Out-of-Pocket Maximum is subject to change each Year. See the Schedule of Benefits at the end of this EOC for this Year's Copayment Out-of-Pocket Maximum. Eligible Charges applied to satisfy deductibles will not count toward satisfaction of the Copayment Out-of-Pocket Maximum. Any Services for which you pay a Coinsurance will not count toward satisfaction of the Copayment Out-of-Pocket Maximum.

The Copayment Out-of-Pocket Maximum may not apply to all Eligible Charges. Copayments for the following Services do not apply to your Copayment Out-of-Pocket Maximum:

- Chemical dependency treatment
- Chiropractic care
- Durable medical equipment
- Dental care
- Hearing aid
- Infertility treatment Services
- Mental health inpatient
- Optical exams or hardware
- Prosthetics and orthotics
- Ostomy and urological supplies
- Prescription drugs
- Continuing or follow-up treatment outside the Service Area

If you or a Family Dependent reach the Copayment

Out-of-Pocket Maximum, there are no more Copayments for these covered Services for the remainder of the Year. Keep your receipts to verify the Copayments you have paid.

**Dependent:** Any person whose relationship to the Subscriber is the basis for membership eligibility and: (i) who meets all applicable eligibility requirements described in the "Premium, Eligibility, Enrollment and Effective Date" section; (ii) who is enrolled hereunder; and (iii) for whom we have received the applicable Premium.

**Eligible Charges:** The amount we use, in part, to determine (a) your Coinsurance; (b) what amount may be applied toward the satisfaction of the Annual Deductible and the Coinsurance Out-of-Pocket Maximum; and (c) the percentage payable by Health Plan. Any amounts in excess of the Eligible Charges will not count toward satisfaction of the Annual Deductible or the Out-of-Pocket Maximums.

Eligible Charges means the following:

1. For Services that Health Plan provides and/or arranges through Medical Group providers and for Services for which the provider is compensated on a capitated basis, the applicable Kaiser Permanente Rate for the particular Service which may include administrative costs;

2. For items covered under "Pharmacy Services" and obtained at a pharmacy owned and operated by Health Plan, Eligible Charges means the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item. This amount is an estimate of: 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; and

3. For all other Services, the least of the Negotiated Rate or the Usual, Customary and Reasonable Charge (UCR), or the charges actually billed by the provider for the covered Service.

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

**Group:** A specific organization such as an employer or an association including a labor union, which shall have a constitution and bylaws and which has been organized and maintained in good faith for purposes other than that of obtaining insurance. The specific organization has entered into a contractual arrangement with Health Plan to provide benefits for eligible persons. The organization must have at least two eligible employees, but not more than 50 to be considered a Small Group, and must have at least 51 eligible employees to be considered a Large Group.

**Health Plan:** Kaiser Foundation Health Plan of Georgia, Inc., a Georgia nonprofit corporation.

**Health Plan Service Area:** Each of the specific geographic areas where Kaiser Foundation Health Plan, Inc. or a related organization conducts a direct service health care program.

**Kaiser Permanente:** Health Plan, Medical Group, or a related organization that conducts a direct service health care program.

**Kaiser Permanente After-Hours Urgent Care Center:** Any non-hospital based outpatient facility designated in your Physician Directory as an After-Hours Urgent Care Center that provides covered Services to Members under this EOC.

**Kaiser Permanente Rate:** The amount that is used to calculate Eligible Charges for certain Services including Services that Health Plan provides through Medical Group providers and for Services for which the Plan Provider is compensated on a capitated basis.

**Maximum Benefit While Covered:** We will pay benefits under this EOC up to the Maximum Benefit While Covered shown in the Schedule of Benefits. The limit applies individually to each Member. When benefits in this amount have been paid or are payable for a Member under this EOC, all coverage for the Member under the applicable benefit or benefits will end. For more information, refer to the "Schedule of Benefits" section at the end of this EOC.

Reinstatement of Your Maximum Benefit While Covered – After the total amount of benefits have been paid for a Member in an amount equal to the Maximum Benefit While Covered shown in the Schedule of Benefits, we will automatically reinstate benefits for the Member each Year in an amount equal to the lesser of:

- $5,000; or
- the amount paid for covered Services incurred in the prior Year.

**Medical Center:** An outpatient treatment facility staffed by Medical Group Physicians and Health Plan staff. Please refer to your Physician Directory for additional information about each Medical Center.

**Medical Group:** The Southeast Permanente Medical Group, Inc.

**Medical Group Physician:** Any licensed doctor of medicine or doctor of osteopathy employed by, or a shareholder or partner in, Medical Group.

**Medical Office:** An outpatient treatment facility staffed by Affiliated Community Physicians throughout the metro-Atlanta area.

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

**Medicare Advantage Plan:** A public or private entity organized and licensed by a State as a risk-bearing entity that is certified by the Centers for Medicare & Medicaid Services (CMS), as meeting the Medicare Advantage requirements. A Medicare Advantage Plan is a product for Medicare beneficiaries offered by a Medicare Advantage Organization that is approved by the Centers for Medicare & Medicaid Services (CMS), as meeting the Medicare Advantage requirements.

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

**Negotiated Rate:** Health Plan or Medical Group may have a contractual arrangement with a provider under which a rate has been negotiated for certain Services. Any such rate is referred to as the Negotiated Rate. If there is a Negotiated Rate, the provider will accept the Negotiated Rate as payment in full for covered Services, subject to payment of deductibles, Copayments and Coinsurance, if any, by the Member.

**Plan:** Kaiser Permanente.

**Plan Physician:** Any Medical Group Physician or Affiliated Community Physician.

**Plan Provider:** A Plan Physician, practitioner, Medical Center, Medical Office, hospital, or other licensed provider of Services listed in the Physician Directory.

**Premium:** Periodic membership charges paid by or on behalf of each Member. The Premium is in addition to any other charges you are required to pay for covered Services.

**Service Area:** The following counties are entirely within the Service Area: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton.

Please notify us immediately if you move outside of our Service Area or are temporarily outside our Service Area for more than 90 days.

**Services:** Any treatment, therapeutic or diagnostic procedure, drug, equipment or device. When a service is excluded, all services that are associated with the excluded service and that would be otherwise covered under this EOC are also excluded.

**Skilled Nursing Facility:** A facility that provides inpatient skilled nursing care, rehabilitation Services, or other related health Services and is certified by Medicare and approved by Health Plan. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in activities of daily living.

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

**Subscriber:** A person who is eligible for membership on his or her own behalf and not by virtue of Dependent status and: (i) who meets all applicable eligibility requirements as described in the "Premium, Eligibility, Enrollment and Effective Date" section; (ii) who is enrolled hereunder; and (iii) for whom we have received the applicable Premium.

**Usual, Customary and Reasonable Charge (UCR):** An amount usually charged by most providers within a geographic region for a specific Service.

**Year:** A period of time that is either a) a calendar year beginning on January 1 of any year and ending at midnight December 31 of the same year; or b) a contract year beginning on an effective date and ending at midnight prior to the anniversary date agreed to by Health Plan and your Group. Refer to the "Schedule of Benefits" section at the end of this EOC to see which period is applicable to this coverage.

# Premium, Eligibility, Enrollment and Effective Date

## Premium

You are entitled to health care coverage only for the period for which we have received the appropriate Premium from your Group. If you are responsible for any contribution to the Premium, your Group will tell you the amount and how to pay your Group (through payroll deduction, for example).

## Who is Eligible

Your Group is required to inform you of its eligibility requirements. To enroll, you and your Dependents must meet your Group's requirements that we have approved, and the Subscriber and Dependents must live in our Service Area at the time of enrollment. For the purposes of this eligibility rule, children are not ineligible solely because they live outside the Service Area, if (1) they are a full-time student in an accredited school or college, or (2) you are required to cover them pursuant

to a Qualified Medical Child Support Order (QMCSO). In addition, your dependents must meet the Dependents eligibility requirements shown below.

Some groups allow those employees who either reside or work within our Service Area to enroll. You should check with your Group about what applies to you. The Service Area is described in the "Definitions" section. In addition, you must meet the Subscriber or Dependent eligibility requirements below. However, your Group may have additional requirements and may not allow enrollment to some persons listed below.

Please check with your Group to confirm who is eligible to enroll.

## Subscribers

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

- an employee of your Group (which includes sole proprietors, partners of a partnership or independent contractor if they are included as employees under the Group's health benefit plan); and work for your employer Group a specified number of hours as determined by your Group, or are on paid leave through your employer Group; or
- otherwise entitled to coverage under a trust agreement or employment contract as approved by Health Plan (except persons who are considered self-employed by the IRS); or
- a Retiree of the Group, as approved by Health Plan.

Subscribers do not include employees who work on a temporary, seasonal or substitute basis.

## Dependents

Your Dependents must meet the Dependent eligibility requirements shown below at the time you enroll, and to continue membership as a Dependent under this EOC.

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

- Your Spouse
- You or your Spouse's unmarried children (including adopted children) who are under:
  - The Dependent limiting age shown in the "Schedule of Benefits" section; or
  - The student Dependent limiting age shown in the "Schedule of Benefits" section and enrolled for five calendar months or more in each calendar year as a full-time student in an accredited school or college; unless enrollment was prevented due to illness or injury and proof of such illness, injury and dependency is given semi-annually if we request it.
- Any other unmarried Dependent persons, who meet all of the following requirements:
  - He or she is under the Dependent limiting age shown in the "Schedule of Benefits" section;
  - He or she receives from you or your Spouse all of their support and maintenance; and
  - You or your Spouse is the legal guardian (or was before the person reached age 18).
- You or your Spouse's Dependents who meet the eligibility requirements stated above, but exceed the Dependent limiting age or the student Dependent limiting age, may be eligible if the following additional requirements are met:
  - He or she is incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to reaching the Dependent limiting age as shown in the "Schedule of Benefits" section;
  - He or she receives from you or your Spouse substantially all of their support and maintenance;
  - He or she permanently resides with you (the Subscriber); and
  - You give us proof of the Dependent's incapacity and dependency annually if we request it.

## Ineligible persons

- If you or your Family have ever had entitlement to receive Services through Health Plan terminated for any of the reasons listed in the "Termination of Membership" section, neither you nor any member of your Family is eligible to enroll in this plan.
- Persons eligible for any part of Medicare as primary coverage may not enroll under this plan. Please call our Senior Advantage Customer Service Department, seven days a week, from 8 a.m. to 8 p.m., at (404) 233-3700 (locally) or 1-800-232-4404 (long distance) or 1-800-255-0056 (TTY).

## Medicare

For Members entitled to Medicare, Medicare is the primary coverage except when federal law (TEFRA) requires that Group's health care plan be primary and

Medicare coverage be secondary. Members eligible for Medicare as their secondary coverage are subject to the same Premium and receive the same benefits as Members who are not eligible for Medicare.

- Premium is based on the assumption that we will receive Medicare payments for Medicare-covered Services provided to Members eligible for benefits under Medicare Part A or B or both. Therefore, you also must complete and submit to us any documents necessary for us to receive Medicare payments for Medicare-covered services we provided or arranged for you after the date you became eligible for Medicare as your primary coverage. Please call us if you have questions about this process. Call our Senior Advantage Customer Service Department, seven days a week, from 8 a.m. to 8 p.m., at (404) 233-3700 (locally) or 1-800-232-4404 (long distance) or 1-800-255-0056 (TTY).

## Loss of Eligibility

**Surviving or Divorced Spouse**

In the event of the death of the Subscriber, the surviving spouse loses eligibility at the end of the month in which the Subscriber died. A divorced spouse of a Subscriber loses eligibility at the end of the month the divorce is final.

**Dependent child**

A child loses eligibility:

- At the end of the month in which the child marries, regardless of age; or
- At the end of the month in which the child reaches the applicable age limit or no longer meets all of the other requirements of this plan for Dependent status.

## Enrollment and Effective Date of Coverage

After your Group has confirmed that you are eligible to enroll, enrollment is permitted as follows and membership begins at 12:01 a.m. on the effective date indicated below.

**New employees**

Once your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days of your eligibility.

Your Group will inform you of the effective date of coverage for you and your eligible Family Dependents.

**Newly acquired Dependents**

To enroll a Dependent who becomes eligible to enroll after you became a Subscriber (including a new Spouse, a newborn child, a child for which a Subscriber is required by an Court or Administrative Order to provide health coverage, or a newly adopted child), you must submit a Health Plan-approved change of enrollment form and a copy of the Order to your Group within 31 days after the Dependent becomes eligible and pay any applicable Premium, as described at the beginning of this section. Also, refer to "Special enrollment due to newly acquired Dependents" below.

Other than a newborn or a newly adopted child, the effective date of coverage for newly acquired Dependents is the first of the month following the application date on the enrollment form.

- An eligible newborn child is automatically covered from the moment of birth. The child must be enrolled within 31 days after birth for membership to continue.
- A newly adopted child's membership will begin on the date of placement for adoption with the adoptive parents or the date of the final decree of adoption, but only if you enroll the child within 31 days.

**Note:** Any applicable Premium must be paid before any newly acquired Dependents coverage becomes effective. If additional Premium is not required you will still need to complete a Status Change form, so that we can send an identification card for your newly added Dependent. In order to be covered, all Services for any newly acquired Dependent must be provided or arranged by a Plan Physician.

**Special enrollment due to loss of other coverage**

You may enroll as a Subscriber (along with any eligible Dependents) and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after the enrolling persons lose other coverage if:

- The enrolling persons had other coverage when you previously declined Health Plan coverage for them (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason); and
- The loss of the other coverage is due to (i) exhaustion of COBRA coverage, or (ii) in the case of non-COBRA coverage, loss of eligibility or termination of employer contributions, but not for individual nonpayment.

Exception: if you are enrolling yourself as a Subscriber along with at least one eligible Dependent, it is necessary for only one of you to lose other coverage and only one of you to have had other coverage when you previously declined Health Plan coverage.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date that your Group receives the enrollment application.

**Special enrollment due to newly acquired Dependents**

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependent (and, if applicable, the new Subscriber) will be:

- For newborn children, the moment of birth. A newborn child is automatically covered for the first 31 days, but must be enrolled within 31 days after birth for membership to continue.
- For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption.
- For all other Dependents, the first of the month following the date the change of enrollment form is signed.

**Open enrollment**

You may enroll yourself and any eligible Dependents, or you may add any eligible Dependents to your existing account (including Dependents not enrolled when first eligible), by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Enrollment rules vary from group to group. You should check with your Group about the rules that apply to you.

# How to Obtain Services

Please read the following information so that you will know from whom or what group of providers you may obtain health care.

Medical care Services for Health Plan Members are provided or directed by The Southeast Permanente Medical Group, Inc. **("Medical Group")** and by physicians **("Affiliated Community Physicians")** who contract with the Medical Group. Medical Group Physicians provide care at Kaiser Permanente Medical Centers **("Medical Centers")** in the Service Area. Affiliated Community Physicians provide care in their own Medical Offices.

The Medical Group and Affiliated Community Physicians assume responsibility for your care; and they either provide your care directly or refer you to specialists for Services that are medically necessary.

You must receive your health care from Medical Group Physicians or Affiliated Community Physicians within our Service Area, except for:

- Emergency Services, as described in the "Benefits" section;
- Authorized referrals, as described in this EOC; and
- Our Visiting Member Program, as described in this EOC.

## Choosing your Personal Physician

Your personal physician plays an important role in coordinating your health care. That's why we encourage you to choose a Plan Physician when you enroll. Every member of your Family should have his or her own personal physician. If you do not select a personal physician upon enrollment, we will assist you by selecting a doctor in a Medical Center or an Affiliated Community Physician near your home and including you in that physician's panel of patients. That doctor will be listed in our records as your personal physician until you select your personal physician and inform us of your decision. You may select your personal physician from Medical Group or Affiliated Community Physicians. The Medical Group Physicians provide care at Kaiser Permanente Medical Centers in our Service Area. An Affiliated Community Physician is a private-practice physician who provides care in his or her own Medical Office. Plan Physicians in family practice, internal medicine or general practice or pediatrics/adolescent medicine may be chosen as a personal physician.

Adults should select an internal medicine, general practice or family practice physician. Parents can choose a pediatric, family practice, or general practice physician for their children, or a family practice physician can be selected for the entire Family. **NOTE**: Some general practitioners only treat adults. Please verify when scheduling an appointment for your child with a general practitioner. Refer to your Physician Directory. To learn how to choose or change a personal physician, please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). You can access our Web site at ***www.kp.org*** for an up-to-date listing of physicians.

## Changing your Personal Physician

You may change your Kaiser Permanente personal physician at any time and as often as you wish. Simply

call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). You also may change your Kaiser Permanente personal physician when visiting one of our Medical Centers (just tell a member of your health care team). Make sure to have your Kaiser Permanente health record number handy when making the change.

## Referrals

You are required to obtain a referral from your Kaiser Permanente personal physician prior to receiving specialty care Services, except as noted below.

If you receive specialty Services for which you did not obtain a referral, you may be responsible for all charges associated with those Services. Additionally, specialty Services must be referred by your personal physician at the time of the referral. If you change personal physicians you will need to discuss the specialty referral need with your new physician.

## Self-Referral

You do not need a referral from your Kaiser Permanente personal physician for appointments with obstetricians/gynecologists, dermatologists, psychia-trists, behavioral health specialists, optometrists, and ophthalmologists. Your personal physician works with specific specialty groups and will recommend a specialist to you. You may also choose one of the self-referral specialist listed in your Physician Directory, or you may call our Customer Service Department at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). Specialists must be contracted with the Medical Group at the time of your self-referral visit.

## Hospital Care

Hospital care arranged by your Plan Physician will generally be provided at one of the hospitals affiliated with Kaiser Permanente. These hospitals are listed in your Physician Directory.

## Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week, anywhere in the world. If you have an Emergency Medical Condition, call 911 or go to the nearest emergency room.

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Determination of whether Services will be covered by Health Plan as Emergency Services is made only after review of the Services obtained.

If you need After-Hours Urgent Care, as described under “Benefits” for an illness or injury of a less critical nature (such as the flu, stomach pain, vomiting, migraine headache, sprain, etc.) you may call our Health Line, 24 hours a day, 7 days a week, (404) 365-0966 (locally), or 1-800-611-1811 (long distance) if you have selected a Medical Group Physician as your personal physician. If you have selected an Affiliated Community Physician, then call your physician’s office if it is during office hours. After office hours call our Health Line at the numbers shown above. After-Hours Urgent Care is available after our regular office hours at After-Hours Urgent Care Centers listed in your Physician Directory.

Our advice nurses, who are registered nurses (RNs), are specially trained to help assess medical problems and provide medical advice when medically appropriate. They can help solve a problem over the phone and instruct you on self-care at home if appropriate. If the problem is more severe and you need an appointment, they will help you get one.

For information about emergency Services or After-Hours Urgent Care refer to "Emergency Services" in the “Benefits" section.

If you need to make a routine care appointment, please call our Health Line Monday through Friday between the hours of 7 a.m. and 7 p.m., at, (404) 365-0966 (locally), or 1-800-611-1811 (long distance) if you have selected a Medical Group Physician as your personal physician. If you have selected an Affiliated Community Physician, then call your physician's office.

## Missed Appointments

You must give at least 24-hours notice to your Plan Provider if you are unable to keep your scheduled appointment. If you do not, you may be required to pay an administrative fee and/or pay for the cost of Services that were specifically arranged for your visit as well as the cost of any drugs and supplies that were prepared for your appointment and that cannot be reused.

## Rescheduling of Services

In the event that you fail to make your deductible, Copayment, or Coinsurance payments, your appointments for non-urgent Services from Plan Providers may be rescheduled until such time as all amounts are paid in full or you have made other payment arrangements with us.

## Our Visiting Member Program

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive certain visiting member Services from designated providers in that area. The covered Services and Copayments may differ from those under this EOC and are governed by our program for visiting members. This program does not cover certain Services, such as transplant, infertility or specialized rehabilitation facility Services. Also, except for Emergency Services, your right to receive health care benefits in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving benefits there.

Please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance) to receive more information about our visiting member program, including facility locations across the United States, and our visiting members brochure. The service areas and facilities where you may obtain visiting member Services can change at any time.

## Moving Outside our Service Area

If you move to another Kaiser Foundation Health Plan or allied plan service area, you may be able to apply to transfer your Group membership if there is an arrangement with your Group in the new service area. Contact our Customer Service Department or the Customer Service Department in the service area to find out how to apply for membership there.

However, eligibility requirements, benefits, Premium, and Copayments may not be the same in the other service area. You should contact your Group's employee benefits coordinator before you move.

If you move outside the Service Area you may continue coverage under this EOC if you satisfy the Group's eligibility requirements and you agree in writing to return to the Service Area to receive all of your covered Services, with the exception of Emergency Services, from Kaiser Permanente. You may do so by completing an Out-of-Area Membership Option Sheet, which may be obtained by calling our Customer Service Department at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

## Using your Identification Card

Each Member has a Health Plan ID card with a Health Record Number on it, which is useful when you call for advice, make an appointment, or go to a Plan Physician for care. The Health Record Number is used to identify your medical records and membership information.

You should always have the same Health Record Number. Please let us know if we ever inadvertently issue you more than one Health Record Number by calling our Customer Service Department Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

**Note:** Neither Health Plan nor Kaiser Permanente physicians will disclose any medical information without your consent except as permitted by law.

The most important information on your card is your health record number. Information about your personal physician will also be printed on your card. If you select a Medical Group Physician, "Permanente Medical Group" will be printed on your card. A sticker with your actual personal physician's name will be affixed to your card during your first visit to the Medical Center. However, if you select an Affiliated Community Physician, your personal physician's name and telephone number will be printed directly on your card. Each time you change Affiliated Community Physicians, switch from an Affiliated Community Physician to a Medical Group Physician, or switch from a Medical Group Physician to an Affiliated Community Physician, you will receive a new card to reflect the change.

Also, your ID card is a useful resource when you call for advice or make an appointment. You should take it with you whenever you have an appointment. Providers may request photo identification together with your ID card to verify identity. If you need to replace your card, please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

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 billed the charges for any Services we provide and claims for Services from non-Plan Providers will be denied. If you let someone else use your I.D. card, we may keep your I.D. card and terminate your membership.

## Member Confidentiality

Health Plan and Medical Group collect various types of protected health information (PHI). PHI is health information that includes your name, social security number, or other information that reveals who you are.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including, among other things, health research and measuring the quality of care and Services. In addition, we are sometimes required by law to give PHI to government agencies or in judicial actions. 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).

We will protect the privacy of your PHI. Health Plan and Medical Group employees are required to maintain the confidentiality of our Members' PHI. All providers with whom we contract are also required to maintain confidentiality.

Subject to limitations imposed under state and federal law, you may generally see and receive copies of your PHI, request that we correct or update your PHI, and request an accounting of certain disclosures of your PHI. Note, if we amend information in your medical record at your request, your original medical record documentation will not be deleted from the medical record.

All requests must be made in writing and should be submitted to the medical record department located in the medical facility that you regularly visit. If you do not know where you received care, the requests should be submitted to the Customer Service Department. Note that we may charge a fee for copies provided to you.

**This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail.**

If you have questions about our policies and procedures to maintain the confidentiality of your PHI or would like a copy of our Notice of Privacy Practices, please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

# General Exclusions, Limitations, Reimbursement of Health Plan, and Coordination of Benefits (COB)

## General Exclusions

Unless otherwise indicated in the Schedule of Benefits, or elsewhere in this EOC, the Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply to a particular Service are listed in the "Benefits" or the "Additional Benefits" section. When a Service is excluded, all related Services are also excluded, even if they would otherwise be covered under this EOC.

**Services that are not medically necessary**

Services that in the judgment of Medical Group or its designee are not medically necessary are excluded.

This exclusion does not apply to preventive or other health care Services specifically covered under this EOC, where medical necessity is not required.

**Cord Blood**

Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient.

**Certain exams and Services**

- Physical examinations and other Services, and related reports and paperwork in connection with third-party requests or requirements, such as those (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance or licensing, or (c) required for foreign travel, (d) required or requested by the judicial system or other government agency, or (e) on court order or required for parole or probation. This exclusion does not apply if it is determined that the Services are medically necessary.
- Services provided, ordered or arranged by criminal justice institutions for Members in the custody of law enforcement officers or non-Plan provider Services provided, ordered or arranged by mental health institutions if confined in the institution, except for emergency Services as described in this EOC.

**Cosmetic Services**

- Plastic surgery or other cosmetic Services, that are intended primarily to change your appearance, and which will not result in significant improvement in physical function.
- Drugs and injectables used in connection with cosmetic Services are also not covered.
- Reconstructive surgery following the removal of breast implants that were inserted for cosmetic reasons.

This exclusion does not apply to:

- Services covered under "Reconstructive Surgery" in the "Benefits" section; and

- Services that are necessary for treatment of a form of congenital hemangioma known as port wine stains on the face of Members 18 years or younger.

**Custodial care**

Custodial care means:

- Assistance with activities of daily living, for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine; or
- Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

**Disposable supplies**

Disposable supplies for home use such as bandages, gauze, tape, antiseptics and ace-type bandages. This exclusion does not apply to disposable needles and syringes for injecting prescribed insulin.

**Employer requirements**

Financial responsibility for Services that an employer is required by law to provide.

**Experimental or investigational Services**

A Service is experimental or investigational if we, in consultation with Medical Group, determine that:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients);
- It requires government approval that has not been obtained when Service is to be provided;
- It cannot be legally performed or marketed in the United States without FDA approval;
- It is the subject of a current new drug or device application on file with the FDA;
- It is provided as part of a research trial;
- It is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service;
- It is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives;
- It is subject to approval or review of an Institutional Review Board or other body that approves or reviews research;
- It is provided pursuant to informed consent documents that describe the services as experimental or investigational, or indicate that the services are being evaluated for their safety, toxicity or efficacy; or
- The prevailing opinion among experts is that use of the services should be substantially confined to research settings or further research is necessary to determine the safety, toxicity or efficacy of the service.

**Eye surgery**

Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism.

**Government agencies**

Financial responsibility for Services that a government agency is required by law to provide.

**Infertility Services or treatment programs**

These exclusions apply to fertile as well as infertile individuals and couples.

- All Services related to conception by artificial means, such as, but not limited to those shown below, are not covered, except where specifically noted to the contrary in the EOC:
  - Infertility drugs, surgical or medical treatment programs, including artificial insemination;
  - Ovum transplants;
  - Gamete intrafallopian transfer (GIFT);
  - Services related to the collection, procurement, washing, preparation or storage of sperm or eggs, including donor fees or cryopreservation;
  - In vitro fertilization (IVF); or
  - Zygote intrafallopian transfer (ZIFT).

**Intermediate care**

Care in an intermediate care facility, or care for which, in the judgment of a Medical Group Physician, the facilities and Services of an acute care general hospital or the extended care Services of a Skilled Nursing Facility are not medically necessary.

**Military services**

Financial responsibility for Services for conditions arising from military service that are reasonably available from the Department of Veterans Affairs.

**Obesity**

All Services and drugs related to the treatment of obesity, except certain health education classes unless

specifically noted to the contrary in the "Additional Benefits Purchased by Your Group" section of this EOC. Services to diagnose the causes of obesity or treatment of diseases resulting from obesity are covered.

**Personal comfort items**

Items such as telephone, radio, television, or grooming services.

**Private duty nursing Services**

Services of a private duty nurse in a hospital, skilled nursing facility or other licensed medical facility, or in the Member's home.

**Routine foot care Services**

Routine foot care Services, such as the trimming of nails, corns and calluses, unless medically necessary due to severe circulatory compromise or similar complicating medical conditions.

**Services for which no charge is normally made**

Services for which no charge is normally made in the absence of insurance.

**Services not generally and customarily provided in our Service Area**

Services not generally and customarily provided in our Service Area, unless it is generally accepted medical practice to refer patients outside our Service Area for such Services.

**Services provided outside the United States**

Services, other than Emergency Services, received outside the United States whether or not the Services are available in the United States.

**Sexual reassignment**

All Services and drugs related to sexual reassignment.

**Services that exceed the UCR**

Charges that are in excess of the UCR from providers, who do not contract with our Medical Group, are not covered.

**Transportation and lodging expenses**

Transportation and lodging expenses for any person, including a Member.

**Workers' compensation or employer's liability**

Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit; but, we may recover the value of any such Services provided under this EOC from the following sources:

- Any source providing a Financial Benefit or from whom a Financial Benefit is due.
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

We are entitled to collect payment of Eligible Charges (as defined in the "Definitions" section) for these Services.

If you receive Services from a non-Plan Provider, we are entitled to recover any amount paid by us for such Services from any liable party or from you.

The following general limitations apply under this Plan:

**Disruption of services**

We will use our best efforts to provide or arrange for your health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this EOC such as:

- Complete or partial destruction of facilities
- War
- Riot
- Civil insurrection
- Major disaster
- Disability of a significant part of Plan hospitals, Medical Group or Affiliated Community Physician personnel
- Epidemic
- Labor disputes beyond our control

However, Health Plan, Medical Group and other Plan Providers will not have any liability for any delay or failure in providing covered Services.

In cases of labor disputes involving Health Plan or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

**Financial responsibility for Services which involve another party liability.**

Refer to Injuries and Illnesses caused by Other Parties.

## Excess Coverage Provision

This coverage pays for Eligible Charges after any group health plan has paid. In no case shall the total payment under this EOC and other coverage exceed 100% of the Eligible Charges. Eligible Charges which are reimbursed by any group health care plan are not covered by this EOC.

## Reimbursement of Health Plan

**Injuries or illnesses caused or alleged to be caused by other parties**

**Services rendered at facilities contracting with Health Plan**

If an injury or illness is caused or alleged to be caused by any act or omission of another party, Services and other benefits that are furnished or arranged by Plan Providers for such injury or illness are payable as Eligible Charges (as defined in the "Definitions" section). Payment of these charges is subject to the provisions of sections "Health Plan's Right of Reimbursement" and "Member's Cooperation Required" shown below.

**Services rendered at facilities not contracting with Health Plan**

If an injury or illness is caused or alleged to be caused by any act or omission of another party, payments to physicians, hospitals, and other providers not contracting with Health Plan are made as described under Emergency Services in the "Schedule of Benefits" section. Reimbursement of these payments is subject to the provisions of sections "Health Plan's Right of Reimbursement" and "Member's Cooperation Required" shown below.

**Health Plan's right of reimbursement**

Subject to the limitations imposed under applicable state or federal law, Health Plan must be paid or reimbursed by you, your estate or legal representative from the proceeds of any settlement, judgment or other amount ("recovery") you receive whether by compromise or otherwise, from or on behalf of any other party for the value of Services provided and expenses covered by both Health Plan and other party recovery. You must hold in trust for us the proceeds of any recovery you receive from or on behalf of the other party pending resolution of Health Plan's interest. Health Plan's right of recovery shall not include any paid Copayments, Coinsurance, non-medical items or expenses for future medical care. Health Plan's right of recovery also extends, but is not limited to any amounts you receive from any insurance policy providing the following coverage: a) liability; b) no fault/med-pay; c) uninsured motorist; or d) underinsured motorist.

**Member's cooperation required**

You must cooperate in protecting Health Plan's interests to payment or reimbursement under sections "Services Rendered at Facilities Contracting with Health Plan" and "Services Rendered at Facilities not Contracting with Health Plan" above, and must not take any action that is harmful to the Plan's rights.

You must notify us of any actual or potential claim or legal action that you anticipate bringing or have brought against another party arising from the alleged acts or omissions no later than 30 days after submitting or filing such claim or legal action. You must complete and submit to us (or our designee), at the address shown below, all consents, releases, authorizations, reimbursement agreements or other documents necessary for Health Plan to determine the existence of any rights it might have under this section, including but not limited to its right of payment or reimbursement and to exercise those rights.

Our address:

**Kaiser Foundation Health Plan of Georgia, Inc.**
**Nine Piedmont Center**
**3495 Piedmont Road, NE**
**Atlanta, Georgia 30305-1736**

**Cancellation of Charges**

If you make reasonable efforts to obtain a recovery because of the injury or illness, and remit any recovery in its entirety to us (or our designee), up to the amount of the payment or reimbursement due us in accordance with applicable State and federal law and under sections "Services Rendered at Facilities Contracting with Health Plan" and "Services Rendered at Facilities not Contracting with Health Plan" above, any amount owed to us that exceeds the recovery shall be canceled. If there is no recovery, all payment and reimbursement responsibility of you under this section is canceled.

**Eligible Charges**

The provisions of this section do not affect your obligations to pay any Eligible Charges due under this EOC.

**Medicare**

Benefits under your group Plan may overlap with the benefits covered by Medicare. We do not duplicate benefits you are entitled to receive under Medicare. Special Medicare rules apply to most employees and their dependents entitled to Medicare.

## Coordination of Benefits (COB)

**This EOC is subject to coordination of benefits rules.** These rules apply when you have health benefits coverage through more than one health care coverage.

Frequently, persons who have a Spouse will have more than one coverage when both work and their employers offer health benefits. There may also be other instances of coverage through more than one plan, such as when you or your Spouse work for more than one employer. This is also known as dual coverage. In cases of dual coverage, special rules apply to the way in which your health benefits will be provided or paid.

The purpose of these rules is to identify a primary plan that will be responsible for paying for your care and a secondary plan, which may pay any amount not paid by the primary plan. When you belong to a health maintenance organization or another type of organization that provides the care directly to you and the plan is secondary, that plan may bill the primary plan for the Services it provides to you. This has no impact upon your right to receive Services from either plan.

**Role of the primary plan.** The primary plan will pay your covered health care expenses, or will provide the Services without seeking payment from any other plan. For example, if we are primary, and you receive Services from us, we will be responsible for the cost of the Services provided to you. If you receive Services covered by us from a non-Plan Provider, as described under the "Emergency Services" section or authorized referrals, we will pay for those Services. In either case, you will be responsible for any Copayment or Coinsurance required under this EOC. However, your secondary plan may reimburse you for the Copayments or Coinsurance that you pay us.

**Role of the secondary plan.** If we are the secondary plan, we may bill your other plan for any Services we provide you. The other plan will pay any amounts it would be obligated to pay for Services rendered to you. In the case of a covered emergency or authorized referral, the other plan would pay the providers of services, and we would pay any amounts that were not paid by your primary plan, up to the amount we would have paid, if we had been the primary plan. In this way, you may receive 100 percent coverage of your health care expenses.

**Determining the primary plan**. A plan is primary when it:

- Does not have a coordination of benefits provision in its contract. It will be primary even if it expressly states that it is secondary to other health benefits coverage.
- Covers you as the Subscriber (it will be the secondary plan for your Spouse).
- Covers your Spouse as the Subscriber (it will be the secondary plan for you).

If you are the Subscriber under more than one plan, the plan that covers you as an active employee is primary.

For your Dependent children, the plan of the parent whose birth month and day occurs the earliest in the calendar year will be primary. For example, if the father's birthday is April 17 and the mother's birthday is April 18, the father's plan is primary and the mother's plan is secondary. For dependent children of divorced parents, the rules vary; we can provide you with those rules by calling our Customer Service Department Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

**The benefit reserve.** When we are secondary and we receive payment from your primary plan under a coordination of benefits situation, or if the other plan pays for Services that we would have paid if we had been primary, a special reserve is established in the name of the person who received the Services. This reserve can be used to pay for any Services provided to that person in the same Year, which are covered by one of the plans, and which are not paid in full (that is, less than 100 percent of the expenses have been paid) by either or both of the plans.

For example, if under our plan, you have to pay a Copayment for an office visit at one of our facilities, then your other plan will not reimburse you for this Copayment because you did not use their plan's providers. In this case you can use your benefit reserve to pay the Copayment. Within the same Year, the date you received the Services and the date that the benefit reserve is created is not important. You may use the reserve to pay Copayments or Coinsurance or to get reimbursed for Copayments or Coinsurance you paid before the reserve was established within the same Year.

The reserve is created only when we are secondary. No reserve is created when we are primary. However, your other coverage should establish a benefit reserve for you when it is secondary.

# Getting Assistance, Filing Claims, and Dispute Resolution

## Getting Assistance

Our Customer Service Department 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 with a Plan Provider, 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 for or to initiate a grievance for any unresolved problem.

We want you to be satisfied with your health care. Please discuss any problems with your personal physician or the other health care professionals who are treating you.

**Complaint procedure**

All people who work with the Kaiser Permanente Medical Care Program share responsibility for assuring Member satisfaction. If you have a problem or concern about Services provided by Plan Providers or about payment for Services by non-Plan Providers, please ask for our help.

Each Kaiser Permanente Medical Center has an administrator who is responsible for concerns involving the Medical Center. If you have a problem with some aspect of medical service by physicians or other providers at one of our Medical Centers, call or visit the administrative office at the Medical Center where you receive your care.

For help with a question or problem involving your coverage (for example, eligibility, enrollment, claims payment, or denial of benefits), call Customer Service at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). A Customer Service Representative will be glad to help.

Give complete information so that the person with whom you speak can work with you to resolve your problem quickly.

- If you are dissatisfied with the way your complaint has been handled, you may request a complaint appeal. To request a complaint appeal, contact the Customer Service Department Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). The Customer Service Department will respond to your request within 30 calendar days.
- If your complaint remains unresolved, you may submit your written complaint to the State of Georgia Office of Insurance and Safety Fire Commissioner or Department of Human Services. We will be sent a copy of your complaint. We will respond in writing to the State of Georgia Office of Insurance and Safety Fire Commissioner or Department of Human Services within 10 working days of receipt of the complaint.

## Notification

If you are admitted to a hospital as a result of an emergency, you should notify us within 24 hours (or as soon as reasonably possible) by calling (404) 365-0966. If calling long distance, dial 1 (800) 611-1811. This will allow us to consult with the physician providing your care and to coordinate further medical care when necessary. By notifying us as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer would have been possible. We will only cover care required before your medical condition permits your travel or transfer to another facility that we designate.

Notification of care differs from authorization. If you notify us through the 24-hour emergency number that you have already received care or if you feel you must seek care without waiting for a return call from us, you must file a claim for those Services to be considered for reimbursement.

## Claims Procedure

**Important information for members whose benefit plans are subject to ERISA**

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates employee benefits, including the claim and appeal procedures for benefit plans offered by certain employers. If your employer's benefit plan is subject to ERISA, each time you request care or Services that must be approved before the care or service is provided, you are filing a "pre-service claim" for benefits. You are filing a "post-service claim" when you ask us to pay for or cover Services that you have already received. You must follow our procedures for filing claims, and we must follow certain rules established by ERISA for responding to your claim.

Send your claim to us within 90 days or as soon as possible after the Service is first rendered, with itemized bills and receipts attached, if you have already paid bills. In no event, will we process claims greater than 12 months from the date the Services were rendered.

**Additional Information for Filing Foreign Claims (Outside of the United States)**

If you are traveling outside of the United States and need to seek urgent or emergent care and you pay for these services out-of-pocket the following information and documentation will need to be submitted to us for review of medical necessity. All information submitted must be in English.

- Emergency and Out-of-Area Claim Form
- Itemized bills from all providers for which you are requesting reimbursement.
- Medical records from the facility (or facilities) that you received care from.
- Copies of receipts that show proof of payment for services rendered. Copies of credit card receipts and credit card statements are acceptable.

- Proof of travel (a copy of boarding passes are acceptable).
- Copy of passport.

**NOTE**: Kaiser Permanente uses Oanda.com when making currency conversions. Currency conversions are based on date of service and not the date of payment unless both dates are the same.

We will review claims that you make for Services or payment, and we may use medical experts to help us review claims and appeals. There are several types of claims, each of which has a different procedure described below:

- post-service claims,
- non-urgent pre-service claims,
- urgent pre-service claims,
- non-urgent concurrent care claims when your course of treatment will expire,
- urgent concurrent care claims when your course of treatment will expire, and
- concurrent care claims when your physician is shortening your course of treatment.

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.

If you miss a deadline for filing a claim or appeal, we may decline to review it. You must meet any deadlines and exhaust the claims and appeals procedures before you can file a demand for arbitration or civil action under ERISA § 502(a)(1)(B). We do not charge you for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

**Post-service Claims**

Post-service claims are requests for payment for Services you already received, including claims for emergency Services. If you have any questions about post-service claims, please call Claims Customer Service at (404) 261-2825. Customer Service can also assist you with questions about the claims procedures in general.

**Procedure for making a post-service claim**

1. 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**
   **Claims Administration**
   **P.O. Box 190849**
   **Atlanta, GA 31119-0849**

2. We will review your claim, and if we have all the information we need, we will make a decision and pay or deny the claim within 15 working days. If we require more information in order to process the claim, we will contact you. 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. If we fail to meet the 15 day deadline, or fail to comply with appropriate notification requirements, we shall pay interest to you or the claim assignee equal to 18% per annum and any amount due by Health Plan.

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.

**Pre-service Claims**

Pre-service claims are requests that we 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 cannot 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 questions about pre-service claims or appeals, please call Customer Service at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

**Procedure for making a non-urgent pre-service claim**

1. Tell Customer Service that you want to make a claim for us 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 Service at (404) 261-2590 (locally) or 1-888-865-5813 (long distance), or mail or deliver a letter to:

**Kaiser Permanente**
**Customer Service**
**Nine Piedmont Center**
**3495 Piedmont Road, NE**
**Atlanta, GA 30305-1736**

2. We will review your claim, and if we have all the information we need we will send you a written decision within 15 days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. 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.

**Procedure for making an urgent pre-service claim**

1. Tell Customer Service that you want to make a claim for us 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 Service at (404) 261-2590 (locally) or 1-888-865-5813 (long distance), or mail or deliver a letter to:

   **Kaiser Permanente**
   **Customer Service**
   **Nine Piedmont Center**
   **3495 Piedmont Road, NE**
   **Atlanta, GA 30305-1736**

2. If we determine that your claim is not urgent, we may treat your claim as non-urgent.

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 72 hours after we receive your claim. If we notify you orally, we will send you a written decision within 3 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 a written decision within 3 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.

**Concurrent Care Claims**

Concurrent care claims are requests that we 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. 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 cannot be adequately managed without the Services you are requesting. If you have any questions about concurrent care claims or appeals, please call Customer Service at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

**Procedure for making a non-urgent concurrent care claim when your course of treatment will expire**

1. Tell Customer Service that you want to make a concurrent care claim for us to continue to approve a 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 Service at (404) 261-2590 (locally) or 1-888-865-5813 (long distance), or mail or deliver a letter to:

   **Kaiser Permanente**
   **Customer Service**
   **Nine Piedmont Center**
   **3495 Piedmont Road, NE**
   **Atlanta, GA 30305-1736**

2. We will review your claim, and if we have all the information we need we will send you a written decision within 15 days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. 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 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.

**Procedure for making an urgent concurrent care claim when your course of treatment will expire**

1. At least 24 hours before the expiration of the course of treatment, tell Customer Service that you want to make an urgent concurrent care claim for us to continue to approve a 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 Service at (404) 261-2590 (locally) or 1-888-865-5813 (long distance), or mail or deliver a letter to:

   **Kaiser Permanente**
   **Customer Service**
   **Nine Piedmont Center**
   **3495 Piedmont Road, NE**
   **Atlanta, GA 30305-1736**
2. If we determine that your claim is not urgent, we may treat your claim as non-urgent.

3. 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 decision within 3 days after that.

4. 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

The process for requesting reconsideration of a denied claim is outlined below. Members covered under an ERISA benefit plan are only required to file one appeal before having a right to take legal action under ERISA to resolve the claim. To submit an appeal, follow the instructions in the denial letter you receive, or if you are unsure, send your appeal to the Appeals Department. They will direct it to the appropriate location for handling.

**Procedure for appealing our denial of a post-service claim**

1. Within 180 days after you receive our written decision denying your claim, tell us that you want to appeal our denial of your claim for us 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 or oral request and the supporting documents constitute your appeal. Follow the instructions in the denial letter you receive, or if you are unsure, you may call the Appeals Department at (404) 364-4862, or mail or deliver a letter to:

   **Kaiser Permanente**
   **Appeals Department**
   **Nine Piedmont Center**
   **3495 Piedmont Road, NE**
   **Atlanta, GA 30305-1736**
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.

**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, tell us that you want to appeal our denial of your claim for us 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. Follow the instructions in the denial letter you receive, or if you are unsure, you may call the Appeals Department at (404) 364-4862, or mail or deliver a letter to:

   **Kaiser Permanente**
   **Appeals Department**
   **Nine Piedmont Center**
   **3495 Piedmont Road, NE**
   **Atlanta, GA 30305-1736**
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.

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

1. Tell us that you want to appeal our denial of your urgent claim for us 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. Follow the instructions in the denial letter you receive, or if you are unsure, you

may call the Appeals Department at (404) 364-4862, or mail or deliver a letter to:

**Kaiser Permanente**
**Appeals Department**
**Nine Piedmont Center**
**3495 Piedmont Road, NE**
**Atlanta, GA 30305-1736**

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 within 72 hours after we receive your appeal. If we notify you orally, we will send you a written decision within 3 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.

**Procedure for appealing our denial of a non-urgent concurrent care claim when your course of treatment will expire**

1. Within 180 days after you receive our written decision denying your claim, tell the Appeals Department that you want to appeal our denial of your concurrent care claim for us 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. Follow the instructions in the denial letter you receive, or if you are unsure, you may call the Appeals Department at (404) 364-4862, or mail or deliver a letter to:

   **Kaiser Permanente**
   **Appeals Department**
   **Nine Piedmont Center**
   **3495 Piedmont Road, NE**
   **Atlanta, GA 30305-1736**

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.

**Procedure for appealing our denial of an urgent concurrent care claim when your course of treatment will expire**

1. Tell us that you want to appeal our denial of your urgent concurrent care claim for us 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.

   Follow the instructions in the denial letter you receive, or if you are unsure, you may call the Appeals Department at (404) 364-4862, or mail or deliver a letter to:

   **Kaiser Permanente**
   **Appeals Department**
   **Nine Piedmont Center**
   **3495 Piedmont Road, NE**
   **Atlanta, GA 30305-1736**

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 3 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.

**Procedure for appealing your physician's decision to shorten your course of treatment**

1. If you receive a written decision from us that says that your physician has decided to shorten your course of treatment, 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 Department at (404) 364-4862, or mail or deliver a letter to:

   **Kaiser Permanente**
   **Appeals Department**
   **Nine Piedmont Center**
   **3495 Piedmont Road, NE**
   **Atlanta, GA 30305-1736**

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 3 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.

# Termination of Membership

## Termination Generally

**Subject to our right or terminate coverage for the reasons described below under the sections entitled "Termination Due to Loss of Eligibility", and "Termination of Group Agreement", we may**

**terminate the membership of the Subscriber and all enrolled Dependents if:**

- Your Group fails to pay us the appropriate Premium due; or
- You perform an act or practice that constitutes fraud, or make an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) misrepresenting membership status, (2) presenting an invalid prescription or physician order, (3) misusing or letting someone else misuse a member ID card, or (4) failing to notify us of family status or Medicare coverage changes that may affect eligibility for membership.

  **Note:** We may report any Member fraud to the authorities for prosecution and pursue appropriate civil remedies.
- You are eligible for Part A and Part B of Medicare but not enrolled in Medicare Part A and Part B or are entitled to Medicare Part A and Part B but have not enrolled under the Evidence of Coverage that Health Plan has for Medicare Members; or
- The Group's membership with a bona fide association is terminated.
- Termination for any of these reasons is effective 30 days after written notice. All rights to benefits cease as of the date of termination. There is no right to convert to non-group coverage.

To the extent required by law, termination shall not prejudice an existing claim initially incurred while your membership was in full force and in effect.

A Member terminated for any reason other than failure to pay may file a timely complaint about the termination, using the complaint procedure described in the "Getting Assistance, Filing Claims, and Dispute Resolution" section. If the complaint is filed on time, then the termination is effective on the later of: (1) 30 days after written notice; or (2) after the final decision under the Complaint Procedure affirming the termination action. A Member who receives notice of termination for failure to pay may avoid termination by paying all amounts due within the 30-day notice period.

## Termination Due to Loss of Eligibility

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

## Termination of Group Agreement

If the Group or Health Plan terminates the Group Agreement, your coverage through the Group will end on the date the Group Agreement terminates subject to continuation of certain benefits for totally disabled Members. See "Continued Benefits For Certain Disabled Members" below.

You may be eligible for Basic or Enhanced Conversion option. See "Conversion" section below.

## Termination for Cancellation or Non-renewal of a Policy Form

If we terminate, cancel or non-renew all coverage under this EOC, we will provide written notice to you and the Group at least 90 days before the date coverage will terminate. We will offer you all other large group employer policies currently being offered or renewed by us for which you are otherwise eligible without regard to any health status related factor. We will act uniformly without regard to the claims experience or any health-status related factor of you or your enrolled Dependents.

## Termination for Discontinuance of a Product

If we cease to offer coverage in the group employer market we will provide written notice to you and the Group at least 180 days before the date coverage will terminate. We will act uniformly without regard to the claims experience or any health-status related factor of you or your enrolled Dependents.

## Continuation of Coverage

Upon loss of eligibility under "Who is Eligible" in the "Premium, Eligibility, Enrollment, and Effective Date" section, you may continue uninterrupted coverage hereunder upon arrangement with Group in compliance with the "Consolidated Omnibus Budget Reconciliation Act of 1985, amendments thereto, and related statutes (collectively "COBRA")" section below or in compliance with the related "Georgia statutes for Continuation of Coverage" section below.

Upon loss of eligibility under "Who is Eligible" in the "Premium, Eligibility, Enrollment, and Effective Date" section, continuation of Group coverage is subject to terms as stated below or, at your option, conversion to non-group membership is available, subject to the terms of the "Conversion" provisions in this section shown below. Upon loss of eligibility under "Who is Eligible" in the "Premium, Eligibility, Enrollment, and Effective Date" section, conversion to non-group

membership is available, subject to the terms of the "Conversion" provisions in this EOC.

**Uniformed Services Employment and Reemployment Rights Acts (USERRA)**

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

**Federal Law**

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

**Georgia Statutes for Continuation of Coverage**

A. A Group Member may continue uninterrupted coverage upon payment of applicable Premium to Group if the Member is a Subscriber, or the Member's coverage is through a Subscriber whose coverage has been effective under this EOC (or under any group policy providing similar benefits which replaces this EOC) for six (6) continuous months immediately prior to termination; unless:

    1. The employment of the Subscriber was terminated for cause; or

    2. The Group coverage was terminated and immediately replaced by similar group coverage;

    3. The Group Agreement was terminated in its entirety or with respect to a class in which the Subscriber belongs; or

    4. The Subscriber failed to pay any contribution required by Group.

B. Coverage under this section continues only:

    1. Upon payment of applicable Premium not to exceed 100% of the established Premium for the Group and at the time specified by Group; and

    2. Until the end of the month in which eligibility terminated and for a period of three (3) consecutive additional months. The terms and conditions of this coverage are governed by the Georgia statutes for Continuation of Coverage.

    3. We may terminate any Member enrolled under "Continuation of Coverage" for whom we do not receive payment when due.

**Continued Benefits for Certain Disabled Members**

If the Group Agreement between Health Plan and Group is terminated a Member who is totally disabled on the effective date of termination shall, subject to all exclusions, limitations and reductions of this EOC, including payment of Copayments, Coinsurance, deductibles and charges in excess of the Eligible Charges, as described in the applicable EOC, be covered for the disabling condition until the earliest of the following events occurs: (1) for 12 months; or (2) until no longer totally disabled; or (3) until the benefits under this EOC expire; or (4) until Medical Group determines that treatment is no longer medically appropriate for the disabling condition. All the provisions of the Group Agreement and this EOC shall apply to such continuation coverage. For purposes of this section, a person is totally disabled if he or she has any medically determinable physical or mental impairment that renders the person unable to (1) do any of the material acts necessary to the transaction of his or her occupation as that occupation is customarily practiced, or (2) perform any of the material activities or duties of individuals of like sex and age, as determined by Medical Group.

## Conversion

If you lose eligibility for group coverage or exhaust group continuation coverage, and you are a qualified eligible individual, you may continue Kaiser Permanente membership by converting to a non-group coverage on a Basic or Enhanced option, on a direct pay basis. If you meet the criteria for Basic conversion, you must apply within 30 days of the date group membership eligibility ends. If you meet the criteria for the Enhanced conversion, you must apply within 63 days of the date group membership eligibility ends. Non-group coverage begins at the time group coverage ends with no break in your coverage. For both Basic conversion and Enhanced conversion, you are directly responsible to Health Plan for the total payment of Premium. **It is important to note that the benefits under a conversion plan may be different than benefits under this plan.** For example, covered Services, Copayments, Coinsurance and other charges under non-group conversion membership may differ from those provided under this EOC.

If you do not convert to non-group coverage, all coverage ceases at the time group or group continuation coverage ends. You must pay the charges for any Services you receive after this date. To determine your eligibility for conversion coverage, please contact our Customer

Service Department at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). A Customer Service representative will be glad to help you.

**Individuals eligible to convert to Enhanced Conversion coverage**

To be eligible to convert to Enhanced Conversion Coverage, you must, at the time membership is terminated in Group, satisfy each of the following conditions:

- Not have or be eligible for any group health insurance coverage;
- Not have had your membership terminated for fraud or misrepresentation;
- Not have had your membership terminated for your failure to pay amounts due. This provision does not apply to other amounts due to us from your Group. If you are terminated because your Group failed to pay Premium, you may still be eligible for Enhanced Conversion;
- Have elected and exhausted all continuation coverage for which the Member is eligible as described in this section;
- Have accumulated at least 18 months of "creditable coverage" (as defined in Official Code of Georgia Annotated section 33-24-21.1(a)(1), as amended). (A Member can aggregate successive periods of coverage provided no lapse of more than 63 days has passed between the termination date of one period of creditable coverage and the effective date of the succeeding period of coverage.);
- Be a legal resident of Georgia;
- Not be eligible for Part A, Part B, or Parts A and B of Title XVIII of the federal Social Security Act (Medicare) or for Title XIX of the federal Social Security Act (Medicaid), or any successors thereto; and
- Notify us in writing within 63 days of the date membership terminates that Member elects Enhanced Conversion Coverage.

**Persons not eligible**

A Member is not eligible to convert to Enhanced Conversion Coverage if this plan terminates as described under this section and Group immediately provides other group coverage or insurance for the Member.

**Individuals eligible to convert to Basic Conversion coverage**

A Member whose membership under this plan is terminated and who is ineligible to elect Enhanced Conversion Coverage as described above may elect Basic Conversion Coverage if such Member was covered under this plan (or any plan which this plan replaces) for at least six continuous months immediately prior to the termination, unless:

- This plan terminates as described in this section and Group immediately provides other group coverage or insurance for the Member; or
- Membership is terminated as described in this section or because Member becomes eligible for Part A, Part B, or Parts A and B of Title XVIII of the federal Social Security Act (Medicare), or any successor program.

You must notify us in writing within 30 days of the date membership under this EOC terminates that you are electing Basic Conversion Coverage.

**Effective date of non-group membership**

Non-Group membership begins when Group membership ends. Covered Services, Copayments, Coinsurance and other charges under non-group membership may differ from those provided under this EOC.

To determine your eligibility for conversion coverage please contact our Customer Service Department Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). A Customer Service representative will be glad to help you.

## Miscellaneous Provisions

**Administration of Agreement**

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

**Agreement binding on Members**

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

**Amendment of Agreement with Group**

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

No agent or other person except an officer of Health Plan has authority to do any of the following: (1) waive any condition or restriction of this Agreement; (2) extend the time for making Premium; or (3) bind Health Plan by making any promises or representations or by giving or receiving any information.

**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.

**Contracts with Providers**

Health Plan and Plan Providers are independent contractors.

Your Plan Providers are paid in a number of ways, including salary, capitation, case rates, fee for service, and incentive payments based on factors such as quality of care, Member satisfaction and other performance measures.

If you would like further information about the way our providers are paid to provide or arrange medical and hospital care for Members, please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

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 physician, we will retain financial responsibility for covered Services you receive from that physician, in excess of any applicable Copayments or Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify you.

In addition, if you are undergoing active treatment from a Plan Provider when the contract with him or her ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible to continue receiving covered care from the terminated physician for your condition. The conditions that are subject to this continuation of care provision are:

- Chronic or terminal illness or if you are inpatient. The Services may be covered for up to 60 days, if necessary for a safe transfer of care to a Plan Provider or other contracting physician as determined by us.
- Covered Services related to pregnancy. Services will be covered for the remainder of that pregnancy, including six weeks of postnatal care if necessary for a safe transfer of care to a Plan Provider as determined by us.

The Services must be otherwise covered under this EOC. Also, the terminated physician must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us.

If you would like more information about this provision, or to make a request, please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

**Governing law**

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

**Member rights and responsibilities**

As a Member, it is important to know your rights and responsibilities. To have a detailed discussion or to obtain a detailed description of your rights and responsibilities, please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

You are our partner in your health care. Your participation in decisions about your health care and your willingness to communicate with your doctor and other health professionals help us to provide you appropriate and effective health care. We want to make sure you receive the information you need to participate in your health care. We also want to make sure your rights to privacy and to considerate care are honored.

As an adult member, you can exercise these rights yourself. If you are a minor, or if you become incapable of making decisions about your health care, these rights will be exercised by the person having legal responsibility for participating in decisions concerning your medical care.

**You have the right to …**

**…participate with practitioners in making decisions about your health care.** This includes the right to receive information you need in order to accept or refuse a treatment that is recommended. Emergencies or other circumstances occasionally may limit your participation in a treatment decision. In general, however, you will not receive any medical treatment before you or your legal representative give consent. You have the right to be informed about and refuse to participate in experimental care proposed by your physicians.

**…a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.**

**…information and assurance of compliance regarding advance directives as described by the provisions of the Patient Self-Determination Act of 1990.** You have the right to choose a person to make medical decisions for you, if you are unable to do so, and to express your choices about your future care. These choices may be expressed in such documents as an Advanced Directive, which includes a durable power of attorney for health care or a living will. You should inform your family and your doctor of your wishes, and give them any documents that describe your wishes concerning future care.

**…receive the medical information and education you need to participate in your health care to ensure a safe course of treatment.** This information includes the diagnosis of a health complaint, the recommended treatment, alternative treatments, and the risk and benefits of the recommended treatment. We will try to make this information as understandable as possible. You also have the right to review and receive copies of your medical records within the established time frame and with associated reproduction costs, unless the law restricts our ability to make them available. You have the right to the consideration of ethical issues that may arise in connection with your health care.

**…for information to be provided to you and your family about the outcomes of care, including unanticipated outcomes.**

**…receive information about the managed care organization, it's services, it's practitioners and providers, and members' rights and responsibilities.**

**…receive considerate, respectful care.** We respect your personal preferences and values.

**…have impartial access to treatment.** You have the right to medically indicated treatment that is a covered benefit which is provided, prescribed or directed by a Medical Group physician, regardless of your race, religion, sex, sexual orientation, national origin, cultural background, physical or mental challenge or financial status.

**…be assured of privacy and confidentiality.** You have the right to be treated with respect and recognition of your dignity and need for privacy. Member information will be handled in a manner to preserve and protect its confidentiality. This includes, but is not limited to, the maintenance of medical records in a secure environment and education of staff regarding confidentiality. Kaiser Permanente will not release your medical information without your authorization, except as required or permitted by law to administer benefits, comply with government requirements or participate in bona fide research or education.

**…have a safe, secure, clean and accessible environment.**

**…participate in physician selection.** You have the right to select and change physicians within the Kaiser Permanente Health Plan. You have the right to a second opinion by a Plan Physician. You have the right to consult with a non-Kaiser Permanente physician at your expense.

**…know and use customer satisfaction resources.** You have the right to know about resources, such as Customer Service and complaint and appeals processes to help answer your questions and solve problems. You have the right to make complaints without concerns that your care will be affected. Your EOC describes procedures to make complaints and appeals.

…**a right to make recommendations regarding the organization's members' rights and responsibilities policies.** We welcome your suggestions and questions about Kaiser Permanente, its services, the health professionals providing care and member's rights and responsibilities.

**…seek financial assistance.** You have the right to speak to a representative in our Patient Business Office if you have extenuating circumstances and are unable to pay the out-of-pocket costs of essential care and Services prescribed by a Southeast Permanente Medical Group provider. The Patient Business Office can provide information on our charity care program and its eligibility requirements.

**You are responsible for …**

**…knowing the extent and limitations of your health care benefits.** An explanation of these is contained in your EOC.

**…identifying yourself.** You are responsible for your membership card, for using the card only as appropriate, and for ensuring that other people do not use your card.

**…keeping appointments.** You are responsible for promptly canceling any appointments that you do not need or cannot keep.

**…providing accurate and complete information.** You are responsible for providing accurate information about your present and past medical condition, as you understand it. You should report any unexpected changes in your condition to your health professional.

**…understanding your health problems and participating in developing mutually agreed upon treatment goals to the degree possible**.

**…following the treatment plan agreed upon by you and your health professional.** You should inform your health professional if you do not clearly understand your treatment plan and what is expected of you. If you believe that you cannot follow through with your treatment, you are responsible for telling your health professional.

**…recognizing the effect of your lifestyle on your health.** Your health depends not just on care provided by Kaiser Permanente, but also on the decisions you make in your daily life, such as smoking or ignoring care recommendations.

**…fulfilling financial obligations.** You are responsible for paying on time any money you owe Health Plan.

**…being considerate of others.** You should be considerate of health professionals and other patients. You should also respect the property of other patients and of Kaiser Permanente.

**Named fiduciary**

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

**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 or enrollment 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.

**Notices**

Our notices to you will be sent to the most recent address we have for you. You are responsible for notifying us of any change in address. Members who move should call our Customer Service Department at (404) 261-2590 (locally) or 1-888-865-5813 (long distance) as soon as possible to give us their new address.

# Benefits

## Introduction

Please refer to the "Schedule of Benefits" section for the amounts, if any, you must pay for covered Services described in this section.

Exclusions and limitations that apply to particular benefits are described in this "Benefits" section. General exclusions and limitations that apply to all benefits are described in the "General Exclusions, Limitations, Reimbursement of Health Plan, and Coordination of Benefits (COB)" section.

The Services described in this "Benefits" section are covered only if all the following conditions are satisfied:

1. A basic requirement of all benefits provided by this plan is that the covered care is medically necessary. The fact that a physician may prescribe, provide or direct a Service does not of itself make it medically necessary or covered by this Plan.

   Medically necessary means Services that, in the judgment of Medical Group Chief of Quality Resource Management or his/her designee, are:

   - Essential for the prevention, diagnosis or treatment of a Member's illness, disease, injury or pregnancy;
   - Appropriate and consistent with the diagnosis and the omission could adversely affect or fail to improve your condition;
   - Based upon generally accepted medical practice in the community in light of conditions at the time of treatment;
   - Appropriate and compatible with regard to standards of acceptable medical care in the United States;
   - Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the problem;
   - Not provided solely for the convenience of the Member or the health care provider or hospital; and
   - Not primarily custodial care.

2. Medical care Services are provided, prescribed, authorized, or directed by a Medical Group Physician or Affiliated Community Physician.

3. The Medical Group Chief of Quality Resource Management or his/her designee determines that the medical care Services are covered benefits.

4. You receive Services at a Medical Center, Medical Office, or Skilled Nursing Facility or other inpatient or outpatient facility designated by Health Plan, inside our Service Area, except where specifically noted to the contrary in this EOC. Note: Please refer to your Physician Directory for the types of covered Services that are available from each facility designated by Health Plan, because at some facilities only specific types of Services are provided.

If you receive Services and we determined the Services are not medically necessary, or are not covered benefits, no benefits will be payable by Health Plan. You will be responsible for all charges for the Services. These charges do not count toward the satisfaction of the Annual Deductible or the Out-of-Pocket Maximums.

## What You Pay

When you access covered Services from a Plan Provider, you may be required to pay out-of-pocket costs such as Copayments, Coinsurance, and Annual Deductibles and/or other deductibles, and any amount in excess of the UCR or Benefit Maximum as shown in the "Schedule of Benefits" section.

These terms are described in the "Definitions" section and applicable amounts are shown in the "Schedule of Benefits" section.

## What We Pay

After you pay the Annual Deductible, Coinsurance, any charges in excess of the Eligible Charges and any other amounts payable by you, we will pay up to the Eligible Charge for covered Services you receive from Plan Providers, provided:

- The expense is for a covered Service that is medically necessary; and
- The expense is incurred while you are a covered Member. To the extent required by law, subsequent membership termination shall not prejudice payment of claims for a covered Service incurred by you while your membership remains in full force and effect.

Our payment:

- Will not exceed the Maximum Benefit While Covered, if any and any other applicable maximum shown in the Schedule of Benefits;
- Will be subject to the limitations shown in the Schedule of Benefits and in this EOC;
- Will be subject to the General Limitations and Exclusions;
- Will be subject to authorization. See "Authorization for Services" shown in this section; and
- Will not exceed Eligible Charges.

## Maximum Benefit While Covered

We will not pay more than the amount of the Maximum Benefit While Covered shown in the "Schedule of Benefits" section for all covered non-Emergency Services you receive from Plan Providers.

## Authorization for Services

**Certain covered Services require authorization as described below in order to be covered. All Services described below may not be covered under your plan. Our Customer Service Department can answer questions about your benefits.**

If you receive Services and authorization was required but not obtained, or the Services are determined not to be medically necessary, no benefits will be payable by Health Plan. You will be responsible for all charges for the Services.

For certain Services, your Plan Physician must obtain approval from Medical Group in advance of your appointment or admission. Before giving approval, the Medical Group Chief of Quality Resource Management or his/her designee considers if the Service is a covered benefit under your plan, medically necessary, and follows general accepted medical practice.

We call this review and approval process authorization.

Authorization is not a guarantee of payment and will not result in payment for Services that are not covered.

Your Plan Physician must obtain authorization for the following Services:

- All inpatient hospital admissions and Services (this does not apply to emergency admissions)
- Inpatient mental health and chemical dependency Services
- Inpatient rehabilitation therapy Services or programs
- Apligraf
- Certain Ambulatory and outpatient Surgeries
- Bariatric Surgery (all visits and procedures)
- Biofeedback and other pain management treatment

- Biventricular pacemaker
- Blepharoplasty
- Breast augmentation
- Breast reduction
- Circumcision (pediatric and adult)
- Cosmetic procedures (any procedure that could be considered cosmetic in nature)
- Craniofacial reconstruction (including but not limited to cleft lip repair)
- Craniotomy
- Dental anesthesia
- Certain Durable Medical Equipment (DME)
- Enteral solutions
- Endoscopy, Wireless Pill Video
- Epidural steroid injections
- Experimental/ investigational procedures and drugs
- Hearing aid
- Home health care
- Home sleep studies for Chronic Obstructive Sleep Apnea
- Hospice
- Hyperbaric Oxygen Treatment (HBO)
- Certain imaging studies (CT angiograms, CT scans, PET scans, MRA and MRI)
- Implantable defibrillators (AICD)
- Infertility Services
- Intacs
- Interstim Therapy
- Intrathecal and epidural infusion pumps
- Laparoscopic Radical Prostatectomy
- Multidisciplinary rehabilitation Services or programs
- Neuropsychological testing
- Orthognathic surgery
- Orthotripsy
- Oxygen therapy
- Pain management
- Penile Prosthesis Insertion
- PET scans
- Prosthetics and Orthotics
- Rehabilitation: ventilator
- Sclerotherapy or other varicose vein treatment
- Septoplasty
- Sexual dysfunction procedures
- Skilled nursing facility Services
- Speech therapy (home or facility)
- Spinal cord stimulation
- Vagal Nerve Stimulation for Epilepsy
- Voluntary termination of pregnancy
- Any request for a referral to a non-Plan provider

(List is subject to change. For the most current information, call our Customer Service Department.)

## Referrals for Services not available from Plan Providers

If your Plan Physician determines and Medical Group approves that you require specific covered Services not available from us, your Plan Physician will refer you to another provider in or out of our Service Area. The Medical Group Chief of Quality Resource Management, or his/her designee, must approve the referral in advance of your appointment with the provider. You must have a referral to the provider in order for us to cover the Services. We will pay the Eligible Charges for covered Services. You pay the Copayments or Coinsurance you would have paid if Services had been provided by a Plan Provider, and any amounts in excess of the Eligible Charges and the UCR.

If you request Services which are not medically necessary or beyond the level of care of the specific Services authorized by us, then you will be responsible for all charges associated with these unauthorized Services, and no benefits will be payable by Health Plan.

## OFFICE SERVICES

We cover the following office Services for diagnosis, treatment and preventive care:

- Primary care visits – Services from internal medicine, family practice, pediatrics; and
- Specialty care visits, including consultation and second opinions with Plan Physician in departments other than those listed under “Primary care visits” above.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Preventive Visits and Services

We cover the following routine outpatient preventive Services:

- Annual routine physical exams for adults;
- Well-child care visits;
- Annual physical exams for children;
- Annual well-woman exams; and
- Immunizations (except travel immunizations).

  Note: You pay your office visit Copayment based on your visit type as described in the Schedule of Benefits. There is no additional Copayment for the preventive health screening tests and procedures listed below.

- Preventive health screening tests and procedures:
  - Chlamydia screening, annually per guidelines.
  - Fasting Lipid Profile, every 5 years starting at age 45.
  - Colorectal cancer screening, including:
    - Fecal occult blood test, annually starting at age 50; and
    - Sigmoidoscopy, every 5 years starting at age 50.
  - Diabetes screening blood glucose test, every 3 years starting at age 45.
  - Mammograms are covered as follows:
    - Age 35 through 39, one during this five year period;
    - Age 40 and over, annually; and
    - When ordered by a Plan Provider.
  - PAP smear, annually.
  - Prostate specific antigen (PSA) test, annually starting at age 50.

Please consult with your personal physician to determine what is appropriate for you.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Maternity Care

We cover all obstetrical care, prenatal visits following the confirmation of pregnancy, intrapartum care (childbirth and delivery including cesarean section), and postnatal visits. Covered Services include care for uncomplicated pregnancy and labor and delivery; spontaneous vaginal delivery; and complications of pregnancy. Complication of pregnancy means conditions requiring hospital confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. Examples include but are not limited to acute nephritis, cardiac decompensation, missed abortion, pre-eclampsia, similar medical and surgical conditions of comparable severity and ectopic pregnancy which is terminated.

Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during pregnancy, morning sickness, hyperemesis gravidarum and similar conditions.

Notes:

- If you are discharged within 48 hours after delivery (or 96 hours if delivery is by cesarean section), your physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge.
- Services provided by an infertility specialist to monitor pregnancy after the conception are considered Infertility Services and are not considered prenatal visits, as described under this benefit, for purposes of benefits provided under this EOC.
- If your newborn remains in the hospital after you are discharged, your newborn's remaining hospital stay is a separate inpatient admission as of your discharge date. All applicable inpatient facility charges and hospital charges will apply to your newborn's stay.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## OUTPATIENT SERVICES

We cover the following outpatient Services only when prescribed as part of care covered under the headings in this "Benefits" section, in conjunction with other parts of this "Benefits" section (for example, diagnostic x-ray and laboratory tests are covered for infertility only to the extent that infertility Services and supplies are covered under "Infertility Services"):

- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available and indicated;

- X-rays and general radiology imaging Services;
- High tech radiology Services (including CT, PET, MRI, myelograms, and Nuclear Medicine scans;

  (List is subject to change. For most current information, call our Customer Service Department.)
- Outpatient surgery (including professional charges);
- Outpatient facility/hospital charges (including professional charges);
- Chemotherapy (and all other visits to infusion centers); and
- Radiation Therapy.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Physical, Occupational, and Speech Therapy, and Cardiac Rehabilitation

All physical therapy, occupational therapy, and speech therapy Services as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

**Physical, occupational, and speech therapy**

We cover prescribed physical therapy, speech therapy, and occupational therapy in the following settings:

- if you are an inpatient in a Plan hospital;
- a Medical Center;
- a Medical Office;
- an outpatient facility designated by Health Plan;
- a Skilled Nursing Facility; or
- as part of Home Health Care.

Your plan may also include day or visit limits. Refer to the "Schedule of Benefits" section for more information.

Visit limits do not apply to covered therapy Services provided in a hospital, Skilled Nursing Facility or as part of covered home health care. Refer to the "Schedule of Benefits" section for your specific benefit.

**Limitations**

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for impairments of specific organic origin.

**Cardiac Rehabilitation**

If in the judgment of the Plan Physician significant improvement is achievable with treatment, we cover prescribed cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction. Covered Services are provided on an outpatient basis and in accordance with Medicare guidelines.

**Physical, Occupational, and Speech Therapy, and Cardiac Rehabilitation Exclusions**

- Long-term physical therapy, speech therapy, occupational therapy and long-term rehabilitation, cognitive rehabilitation programs, vocational rehabilitation programs, and therapies and rehabilitation done primarily for education purposes are not covered.
- Maintenance programs and Services related to activities such as prevention that is not related to the treatment of an injury or ailment, general exercises to promote overall fitness, wellness and flexibility, and activities to provide diversion or general motivation are not covered.
- Speech therapy that is not medically necessary is not covered, such as:
  - Therapy for educational placement or other educational purposes;
  - Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation;
  - Therapy for tongue thrust in the absence of swallowing problems; and
  - Voice therapy for occupation or performing arts.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Dialysis Care

If the following conditions are met, we cover dialysis Services related to acute renal failure and end-stage renal disease:

- The Services are provided inside our Service Area;
- You satisfy all the medical criteria developed by the Medical Group and by the facility providing the dialysis;
- The Services are provided in an acute hospital or a facility designated by Health Plan. The facility must be certified by Medicare; and
- A physician provides a written referral for your dialysis treatment.

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

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## EMERGENCY SERVICES

If you have an Emergency Medical Condition, call 911 or go to the nearest emergency room.

Coverage is provided for hospital emergency room care for initial Services rendered for the onset of symptoms of an Emergency Medical Condition. An emergency room Copayment or Coinsurance is required for initial Services rendered in the emergency room of a hospital. You are responsible for the Copayments, deductibles or Coinsurance, and any charges in excess of the Eligible Charges. The Copayment for emergency room visits (if applicable to your plan) will be waived if you are directly admitted to the hospital as an inpatient from the emergency room. Your inpatient Services charges will still apply.

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Medically necessary emergency Services include psychiatric emergency care provided in an emergency room and emergency care related to alcohol or drug abuse, such as treatment for overdose.

To better coordinate your emergency care, if you are inside the Service Area, you should go to the Plan hospital if possible.

If you are admitted to a hospital as a result of an emergency, you should notify us within 24 hours or as soon as reasonably possible by calling our Health Line at (404) 365-0966. If calling long distance, dial 1-800-611-1811. This will allow a Medical Group Physician or an Affiliated Community Physician to consult with the physician providing your care and to coordinate further medical care when necessary. By notifying us as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer would have been possible. We will only cover care that is required before your medical condition permits your travel or transfer to another facility that we designate.

We cover medically necessary ambulances. An ambulance is considered medically necessary when the patient's condition is so critical that life or health would be threatened if treatment were delayed by using any other transportation.

If you become ill or are injured while outside the Service Area on business or pleasure, we will cover Emergency Services. Covered benefits include medically necessary Emergency Services for conditions, which arise unexpectedly, such as myocardial infarction, appendicitis or premature delivery. Medically necessary Services for conditions which you are aware of and should have known might require treatment while outside the Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery, full-term delivery or care for a chronic medical condition, will not be covered under your benefits.

**Post-stabilization Care, Continuing or Follow-up Treatment**

Post-stabilization care from a non-Plan Provider is covered when you require medically necessary non-emergency Services to ensure that you remain stabilized after an emergency from the time a non Plan Physician requests authorization from us until one of the following events:

- You are discharged from the non–Plan hospital;
- We assume responsibility for your care; or
- We and the non–Plan Physician agree to other arrangements.

We limit coverage to Emergency Services received before you can, without medically harmful consequences, be transported to another medical facility designated by us. A decision to transfer you to another facility is made at our discretion with the attending physician's concurrence. We cover special transportation to another facility if we approve it in advance.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Ambulance Services

We cover the Services of a licensed ambulance only if your condition requires the use of Services that only a licensed ambulance can provide and the use of other means of transportation would endanger your health. We will not cover ambulance Services in any other circumstances, even if no other transportation is available. We cover ambulance Services only inside our Service

Area, except as covered under "Emergency Services" in this "Benefits" section.

**Ambulance exclusion**

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

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## After-Hours Urgent Care

We cover Services for unexpected illness or injury that does not meet the criteria described under "Emergency Services". Services must be obtained during designated "After Hours" in Kaiser Permanente After-Hours Urgent Care Centers, or at our Affiliated Community After-Hours Urgent Care Centers designated by Health Plan.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

# INPATIENT SERVICES

## Hospital Inpatient Care

All Plan hospital admissions, except for Emergency Services as described in "Emergency Services" in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

We cover the following types of inpatient Services in a Plan hospital only as described under these headings in this "Benefits" section, 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 and special nursing care;
- Special diet;
- Operating and recovery room;
- Physician and other professional Services (such as anesthesiologist, pathologist, radiologist, surgeon);
- Anesthesia;
- Other hospital Services and supplies;
- Dressings and casts;
- Blood, blood products, and their administration. In addition, the collection and storage of autologous blood for elective surgery is covered when authorized by a physician;
- Respiratory therapy; and
- Medical social services and discharge planning.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

# MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

## Mental Health Services

**Outpatient mental health Services**

We cover Services received in the Medical Center, Medical Office or other facility designated by Health Plan for:

- Diagnostic evaluation and psychiatric treatment, and individual therapy visits, per 50-55 minute outpatient visit;
- Group therapy visits; and
- Visits for the purpose of monitoring drug therapy.

**Inpatient mental health Services**

All inpatient Mental Health Services as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

We cover the following mental health Services only for mental health conditions that a Medical Group Physician believes will significantly improve with relatively short-term therapy:

- Evaluation,
- Crisis intervention, and
- Treatment.

Mental health Services are provided by Medical Group Physicians and psychologists, psychiatric social workers, Medical Group certified nurse specialists, and professional counselors in Medical Group.

**Inpatient psychiatric care**

We cover Services for short-term psychiatric hospitalization in a Plan hospital. These Services include Services of Medical Group Physicians and other mental

health professionals in Medical Group when performed, prescribed or directed by the Medical Group Physician, including: individual therapy, group therapy, shock therapy, drug therapy, and psychiatric nursing care.

**Hospital alternative Services**

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric care. Hospital alternative Services include the following:

- Partial hospitalization and treatment in an intensive outpatient psychiatric treatment program.
- Day or night treatment programs. Each session of day or night treatment is less than 8 hours.

**Mental health Services exclusions**

- Marriage and couples counseling.
- Services after diagnosis for conditions that, in the professional judgment of a Medical Group Physician, are not responsive to short-term therapeutic management are not covered. These excluded conditions include:
  - Chronic psychosis, except that acute episodes due to a chronic psychotic condition are covered if the patient has been cooperative and has responded favorably to an ongoing treatment plan.
  - Chronic organic brain syndrome, except that treatment for acute organic brain syndromes and acute episodes due to a chronic organic brain syndrome is covered.
  - Intractable personality disorders.
  - Mental retardation.
- Outpatient drugs unless they are covered under "Pharmacy Services".
- Services for patients who, in the judgment of a Medical Group Physician, are seeking Services for other than therapeutic purposes are not covered.
- Psychological testing for ability, aptitude, intelligence, or interest is not covered.
- Mental health Services that are primarily educational are not covered.
- Special education and related counseling or care for learning deficiencies or behavioral problems.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Chemical Dependency Services

**Outpatient and Inpatient Detoxification Services**

All inpatient Chemical Dependency Services described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

We cover outpatient and inpatient Services to control the physiological complications of and withdrawal from alcohol and drug addiction.

**Chemical dependency exclusions**

- Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as described above. In appropriate cases, we will provide information to you on where to obtain non-covered Services.
- Services for treatment and counseling except where specifically noted to the contrary in this EOC.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

**Your Group may have purchased additional Chemical Dependency Services benefits. Refer to the "Additional Benefits Purchased by Your Group" section to find out.**

# PHARMACY SERVICES

## Administered drugs

The following drugs and supplies are covered only if they require administration or observation by medical personnel and they are administered to you in a Plan hospital, Medical Center, Medical Office, outpatient facility designated by Health Plan, Skilled Nursing Facility or during home visits.

- Drugs, injectables, and radioactive materials used for therapeutic purposes;
- Vaccines approved for use by the Federal Food and Drug Administration (FDA);
- Immunizations approved for use by the Federal Food and Drug Administration (FDA). Immunizations that are developed after March 1 of the year immediately preceding the year this EOC became effective or was last renewed and in general use are payable at half of the Eligible Charges;
- Intravenous (IV): drugs, fluids, additives, and nutrients; and the supplies and equipment required for their administration;

- Allergy test and treatment materials when administered in an outpatient setting.

**Special note about our drug formulary**

The Kaiser Permanente drug formulary is a list of prescription drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is comprised of Plan Physicians and other Plan Providers, selects prescription drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The Pharmacy and Therapeutics Committee meets several times each year to consider adding and removing prescription drugs on the drug formulary.

If you request a non-formulary drug – although your physician feels there is an acceptable formulary alternative – you will be responsible for the full cost of that drug.

However, if your Plan Physician believes that:

- A non-formulary drug best treats your medical condition;
- A formulary drug has been ineffective in the treatment of your medical condition; or
- A formulary drug causes or is reasonably expected to cause a harmful reaction,

then an exception process is available to your Plan Physician. In that case, your standard Copayment or Coinsurance would apply.

**Review and Authorization**

Certain prescription drugs require review and authorization prior to dispensing. Your Plan Physician must obtain this review and authorization. The list of prescription drugs requiring review and authorization is subject to periodic review and modification by our Pharmacy and Therapeutics Committee.

If you would like information about:

- whether a particular drug is included in our drug formulary,
- obtaining a formulary brochure that lists the formulary drugs and provides more information about our drug formulary, or
- whether a drug requires authorization,

please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).

**Pharmacy Services Exclusions**

- Unless an exception is made by Health Plan, drugs not approved by the Food and Drug Administration and in general use as of March 1 of the year immediately preceding the year in which this EOC became effective or was last renewed are not covered.
- Immunizations and other drugs and supplies needed solely for travel are not covered.
- If a Service is not covered under this EOC, any drugs and supplies needed in connection with that service are not covered.
- Drugs and injectables for the purpose of weight loss or the treatment of obesity are not covered, except where specifically noted to the contrary in this EOC.
- Drugs and injectables used in connection with cosmetic Services are not covered.
- Drugs and injectables for the treatment of sexual dysfunction disorders are not covered, except where specifically noted to the contrary in this EOC.
- Drugs and injectables for the treatment of involuntary infertility are not covered, except where specifically noted to the contrary in this EOC.
- Contraceptive drugs, including administered and internally implanted contraceptives are not covered, except where specifically noted to the contrary in this EOC.

Internally implanted contraceptives, injectable contraceptives, and other time released drugs are not covered under this section.

**Your Group may have purchased additional Pharmacy Services benefits. Refer to the "Additional Benefits Purchased by Your Group" section to find out.**

## OTHER SERVICES

### Skilled Nursing Facility Care

All Skilled Nursing Facility Care as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

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

We cover the following Services:

- Physician and nursing Services;
- Room and board;
- Medical social Services;
- Drugs covered under "Pharmacy Services";
- Blood, blood products, and their administration;
- Durable medical equipment ordinarily furnished by a Skilled Nursing Facility, including oxygen-dispensing equipment and oxygen;
- Procedures covered under "Outpatient Services";
- Services covered under "Physical, Occupational, and Speech Therapy, and Cardiac Rehabilitation";
- Respiratory therapy;
- Biological supplies; and
- Medical supplies.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" for more information.**

## Home Health Care

Home health care is a program for your care and treatment at home. The program consists of skilled care, which may include observation, evaluation, teaching and skilled nursing Services, medically consistent with your diagnosis.

All home health care Services as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

We cover the following home health care Services only within our Service Area and only if you are confined in your home. The Services are covered only if a Plan Physician determines the Services are medically necessary and that it is feasible for health care personnel to maintain safe, effective supervision and control of your care in your home. Services are subject to continuing review based on these criteria and in accordance with our guidelines.

- Part-time or intermittent skilled nursing care visits provided by or under the supervision of a registered nurse;
- Part-time or intermittent home health aide Services, provided in conjunction with skilled nursing care, physical therapy, occupational therapy, or speech therapy;
- Medical social services;
- Physical, occupational, speech or respiratory therapy Services; and
- Medical supplies and durable medical equipment.

Covered Services are limited to part-time or intermittent care. Part-time or intermittent care means covered home health Services generally furnished less than eight hours each day and 28 or fewer hours each week.

Services provided or needed at a greater frequency or intensity, or on an ongoing hourly basis in order to meet the patient's skilled needs, are considered private duty nursing Services.

Your plan may include day or visit limits. Refer to the "Schedule of Benefits" for more information.

- Each visit by health care personnel is generally no more than 4 hours. Each 4 hours of home health Services received from health care personnel in a 24-hour period is considered one home health visit.

The following types of Services provided during covered home health care Services are covered only as described under these headings in this "Benefits" section:

- Pharmacy Services;
- Durable Medical Equipment (DME);
- Physical, Occupational, and Speech Therapy, and Cardiac Rehabilitation;
- Ostomy and Urological Supplies; and
- Prosthetics and Orthotics.

**Home health care exclusions**

The following types of Services are not covered:

- Custodial care (see definition under "Exclusions" in the "General Exclusions, Limitations, Reimbursement of Health Plan, and Coordination of Benefits (COB)" section).
- Homemaker Services.
- Meals, personal comfort items and housekeeping services.
- Private duty nursing Services.
- Services of a person who normally lives in the home or who is a member of the family.
- Care that the Medical Director of the Medical Group or his/her designee determines may be appropriately provided in a Plan hospital, Medical Center, Medical Office, Skilled Nursing Facility, or other facility designated by Health Plan and we provide, or offer to provide, that care in one of these facilities.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" for more information.**

## Hospice Care

We cover hospice care which includes caring for the terminally ill that emphasizes palliative and supportive Services, such as home care and pain control, rather than treatment of the terminal illness. We cover hospice care only within our Service Area and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home. If a physician diagnoses you with a terminal illness and determines that your life expectancy is six months or less, you can choose home-based hospice care instead of traditional Services otherwise provided for your illness. If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this EOC. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.

We cover the following Services when approved by a Plan Physician and our hospice care team and provided by a licensed hospice agency approved in writing by the Medical Group:

- Physician and nursing care;
- Therapy, such as physical, occupational, or respiratory therapy, or therapy for speech-language pathology, for purposes of symptom control to enable the person to maintain activities of daily living and basic functional skills;
- Medical social Services;
- Home health aide;
- Homemaker Services;
- Palliative drugs prescribed for the terminal illness in accord with our drug formulary guidelines. You must obtain these drugs from our Kaiser Permanente Medical Center pharmacy or a community pharmacy designated by Health Plan;
- Durable medical equipment is covered only as described under "Durable Medical Equipment (DME)";
- Short-term inpatient care, including respite care, care for pain control, and acute and chronic symptom management;
- Counseling and bereavement services for the individual and family members;
- Services of volunteers; and
- Medical supplies and appliances.

**Hospice care exclusions**

If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this EOC.

Hospice Care is usually provided at No Charge. Refer to the "Schedule of Benefits" section for more information.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Dental care

We cover the following dental care Services:

- Dental care and appliances to repair accidental injury to mouth, jaw, and sound and natural teeth, necessitated solely because of accidental bodily injury which is the direct result of an accident, independent of disease or bodily infirmity or any other cause. In order to be covered, the dental care must be completed within 365 days of such injury.
- Non-surgical dental treatment, including splints and appliances, for Temporomandibular Joint Dysfunction. Services must be provided by a Plan dentist designated by Health Plan. For a list of dentists who have agreed with Health Plan to provide Members with the covered dental Services specified in this Section, you may call our Customer Service Department Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance).
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- General anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care are covered when provided in a hospital or outpatient facility designated by Health Plan for persons:
    - 7 years of age or younger, or;
    - who are developmentally disabled, or;
    - who are not able to have dental care under local anesthesia due to a neurological or medically compromising condition, or;
    - who have sustained extensive facial or dental trauma.

**Dental Care exclusions**

Unless otherwise noted to the contrary in this EOC, dental Services that are not covered include, but are not limited to:

- Services to correct malocclusion;
- Extraction of teeth;

- Routine or preventive dental care and dental X-rays;
- Injuries to teeth resulting from biting or chewing;
- Dental appliances;
- Dental implants;
- Orthodontics;
- Dental Services associated with medical treatment including surgery on the jawbone, except as described under Dental Care shown above; and
- All hospital Services for dental care, except as described under Dental Care shown above.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

**Your Group may have purchased additional Dental Care Services benefits. Refer to the "Additional Benefits Purchased by Your Group" section to find out.**

## Durable Medical Equipment (DME)

All Durable Medical Equipment as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

Within our Service Area, we cover durable medical equipment prescribed in accord with Medicare guidelines and approved for coverage under Medicare as of January of the year immediately preceding the year this EOC became effective or last renewed. Durable medical equipment also includes infant apnea monitors.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Durable medical equipment is equipment that is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury. We cover durable medical equipment, including, oxygen-dispensing equipment and oxygen, for use during a covered stay in a Plan hospital or a Skilled Nursing Facility, if a Skilled Nursing Facility ordinarily furnishes the equipment. If a Plan Physician prescribes and Medical Group approves this equipment for use in your home (or an institution used as your home), we cover the equipment while you use it as prescribed.

We decide whether to rent or purchase the equipment, and we select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when it is no longer prescribed.

Your plan may also include benefit maximum. Refer to the "Schedule of Benefits" section for more information.

- Comfort, convenience, or luxury equipment or features are not covered.
- Exercise or hygiene equipment is not covered.
- Non-medical items such as sauna baths or elevators are not covered.
- Modifications to your home or car are not covered.
- Devices for testing blood or other body substances are not covered, except diabetic testing equipment and supplies as described under "Pharmacy Services".
- Electronic monitors of bodily functions are not covered, except infant apnea monitors and blood glucose monitors.
- Disposable supplies are not covered.
- Replacement of lost equipment is not covered.
- Repair, adjustments or replacements necessitated by misuse are not covered.
- More than one piece of durable medical equipment serving essentially the same function is not covered, except for replacements other than those necessitated by misuse or loss.
- Spare or alternate use equipment is not covered.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Prosthetics and Orthotics

All Prosthetics and Orthotics as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

We cover the devices listed below if they are prescribed in accord with Medicare guidelines and approved for coverage under Medicare as of January of the year immediately preceding the year this EOC became effective or was last renewed. In order to be covered, the device must be in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Also, coverage is limited to the standard device that adequately meets your medical needs.

We select the provider or vendor that will furnish the covered device. Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and Services to determine whether you need a prosthetic or orthotic device.

**Internally implanted devices.** We cover internal devices implanted during covered surgery, such as pacemakers and hip joints, that are approved by the federal Food and Drug Administration for general use.

**External devices.** We cover rigid or semi-rigid external devices, other than casts, which are:

- Required to support or correct a defective form or function of an inoperative or malfunctioning body part.
- To restrict motion in a diseased or injured part of the body.
- To replace all or any part of a body organ or extremity.
- Therapeutic footwear for severe diabetic foot disease in accord with Medicare guidelines.

Devices must be prescribed by a Plan Physician, and approved by Medical Group, and obtained from sources designated by Health Plan.

Your plan may also include a benefit maximum. Refer to the "Schedule of Benefits" section for more information.

**Prosthetics and orthotics exclusions**

- Dental prostheses, devices, implants and appliances under this benefit are not covered (see "Dental Care" section).
- External and internally implanted hearing aids under this benefit are not covered, except where specifically noted to the contrary in this EOC.
- Eyeglasses and contact lenses are not covered, except where specifically noted to the contrary in this EOC.
- Low vision aids are not covered.
- Nonrigid supplies, such as elastic stockings and wigs are not covered.
- Comfort, convenience, or luxury equipment or features are not covered.
- Electronic voice-producing machines are not covered.
- Shoes or arch supports or other shoe inserts, even if custom-made are not covered, except for severe diabetic foot disease in accord with Medicare guidelines.
- More than one orthotic or prosthetic device for the same part of the body are not covered, except for replacements other than those necessitated because of misuse or loss.
- Replacement of lost prosthetic or orthotic devices are not covered.
- Repair, adjustments or replacements necessitated by misuse are not covered.
- Spare or alternate use equipment is not covered.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Ostomy and Urological Supplies

We cover catheters, ostomy, and urological supplies prescribed in accord with Medicare guidelines and approved for coverage under Medicare as of January of the year immediately preceding the year this EOC became effective or was last renewed, during a covered stay in a facility designated by Health Plan, or for home use. Coverage is limited to the standard item of equipment that adequately meets your medical needs.

Your plan may also include a Benefit Maximum. Refer to the "Schedule of Benefits" section for more information.

**Ostomy and urological supplies exclusions**

- Comfort, convenience, or luxury equipment or features are not covered.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

## Infertility Services

All Infertility Services as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

We cover Services for the diagnosis of involuntary infertility. Services include diagnostic imaging and laboratory tests, limited to hysterosalpingogram (HSG), fasting blood glucose, fasting insulin, semen analyses, tests to rule out sexually transmitted diseases and hormone level tests. This benefit includes diagnosis of both male and female infertility, however Services are covered only for the person who is the Member.

**Notes:**

- Infertility drugs and supplies are not covered under this section (refer to "Pharmacy Services").

- Services provided by an infertility specialist to monitor pregnancy after the conception are considered Infertility Services and are not considered prenatal visits, as described under Maternity Care, for purposes of benefits provided under this EOC.

**Infertility Services exclusions**

- Services to reverse voluntary, surgically induced infertility are not covered.
- Services to further diagnose and treat infertility that are beyond the Services noted above are not covered, unless your Group has purchased additional coverage for this benefit.
- Infertility drugs are not covered, unless your Group has purchased additional coverage for this benefit.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

**Your Group may have purchased additional Infertility Services benefits. Refer to the "Additional Benefits Purchased by Your Group" section to find out.**

## Family Planning Services

We cover the following:

- Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control,
- Tubal ligations, and
- Vasectomies

**Note:** Diagnostic procedures are not covered under this section (see "Outpatient Services"). Also, contraceptive drugs and devices are not covered under this section (see "Pharmacy Services"). Certain Family Planning Services may be provided as outpatient procedures or outpatient surgery. Refer to those benefits in the "Schedule of Benefits" section to understand what you will be required to pay for Services.

**Family Planning Services exclusions**

Family Planning Services do not include:

- Artificial insemination
- Other assistive reproductive technologies

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. The benefits described above are covered the same as any other illness. Refer to Office Services and Inpatient Services in the "Schedule of Benefits" section for more information.**

## Hearing Services

We cover hearing tests to determine the need for hearing correction.

**Hearing Services exclusions**

- Tests to determine an appropriate hearing aid are not covered.
- Hearing aids or tests to determine their efficacy are not covered.
- Internally implanted hearing aids are not covered, except where specifically noted to the contrary in this EOC.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to Office Services in the "Schedule of Benefits" section for more information.**

**Your Group may have purchased additional Hearing benefits. Refer to the "Additional Benefits Purchased by Your Group" section to find out.**

## Reconstructive Surgery

All Reconstructive Surgery as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

We cover the following types of reconstructive surgery:

- Reconstructive surgery that a Plan Physician determines will result in significant change in physical function for conditions that result from congenital abnormalities, medically necessary surgery, or injuries.
- Reconstructive surgery that a Plan Physician determines will correct a significant disfigurement caused by medically necessary surgery or by an injury.
- Reconstructive surgery incident to a mastectomy. Prostheses are covered only as described under "Prosthetics and Orthotics".
- Reconstructive surgery performed to restore and achieve symmetry following a mastectomy.
- Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face of Members 18 years or younger.

**Reconstructive surgery exclusions**

- Cosmetic surgery, plastic surgery, or other Services, other than those listed above, that are intended primarily to change your appearance, or will not result in significant improvement in physical function are not covered.

- Surgery that is performed to alter or reshape normal structures of the body in order to change appearance is not covered.
- Surgery after removal of breast implants originally inserted for cosmetic reasons is not covered.
- Prosthetic and orthotic devices are covered only as described under "Prosthetics and Orthotics".

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. The benefits described above are covered the same as any other illness. Refer to Office Services and Inpatient Services in the "Schedule of Benefits" section for more information.**

## Transplant Services

All Transplants as described in this section must be authorized by the Medical Group Chief of Quality Resource Management or his/her designee as described under "Authorization for Services" at the beginning of this section.

- We cover the following transplants and related Services:
  - bone marrow
  - cornea
  - heart
  - heart/lung
  - kidney
  - liver
  - pulmonary
  - small bowel
  - pancreas
  - simultaneous pancreas-kidney

We cover Services for a donor or an individual identified by Medical Group as a prospective donor that are directly related to a covered transplant for you.

The transplants are covered if the following criteria are met:

- You satisfy all medical criteria developed by Medical Group and by the facility providing the transplant; and
- Medical Group provides a written referral for care at the facility.

After the referral to a transplant facility, the following applies:

- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will pay only for covered Services you receive before that determination is made.
- Health Plan, Plan hospitals, Medical Group, and other Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of a donor organ, a bone marrow or organ donor or the availability or capacity of referral transplant facilities.
- If the expenses are directly related to a covered transplant, we cover reasonable medical and hospital expenses for a donor, or an individual identified by Medical Group as a potential donor, even if not a Member.

**Transplant Services exclusions**

- Services related to non-human or artificial organs and their implantation are not covered.
- Transportation or lodging expenses for any person, including the Member are not covered.
- Ambulance Services are not covered (except medically necessary ambulance service).

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. The benefits described above are covered the same as any other illness. Refer to Office Services and Inpatient Services in the "Schedule of Benefits" section for more information.**

# IMPORTANT Notices Regarding Your Health Insurance Coverage

## Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 was passed into law on October 21, 1998. This federal law requires all health insurance plans that provide coverage for a mastectomy must also provide coverage for the following medical care:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications at all stages of the mastectomy, including lymphodemas.

We provide medical and surgical benefits for a mastectomy. Covered benefits are subject to all provisions described in your plan, including but not limited to, Copayments, Coinsurance, deductibles, exclusions, limitations and reductions.

## Newborn Baby and Mother Protection Act

The Newborn Baby and Mother Protection Act (Code Section 33-24-58.2 of the Georgia Law) requires that health benefit policies which provide maternity benefits must provide coverage for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newborn child. The care must be provided in a licensed health care facility.

A decision to shorten the length of stay may be made only by the attending health care provider after conferring with the mother. If the stay is shortened, coverage must be provided for up to two follow-up visits with specified health care providers with the first visit being within 48 hours after discharge. After conferring with the mother, the health care provider must determine whether the initial visit will be conducted at home or at the office and whether a second visit is appropriate. Specified services are required to be provided at such visits.

Covered benefits are subject to all provisions described in your plan, including but not limited to, Copayments, Coinsurance, deductibles, exclusions, limitations and reductions.

# Additional Benefits Purchased by Your Group

In addition to the standard benefits described in the "Benefits" section of this EOC, you are entitled to the following additional benefits purchased by your Group.

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## Domestic Partner

For purposes of this EOC, a Family Dependent includes a Domestic Partner. Except for the "Definitions" section, the term "Spouse" is replaced with "Spouse or Domestic Partner" throughout this EOC so that provisions applicable to an eligible Spouse are also applicable to an eligible Domestic Partner. The term "Spouse" is defined as your legal husband or wife.

A Domestic Partner is a person who meets all the requirements shown on the Declaration of Domestic Partnership.

Health Plan may require proof of the establishment of a Subscriber's domestic partnership and Group and Subscriber agree to provide such proof promptly upon request.

A person is eligible to enroll as a Domestic Partner only when all of the Domestic Partner requirements shown on the Declaration of Domestic Partnership have been met, and an accurate and completed Declaration form has been submitted.

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## Chemical Dependency Services

## Treatment

We cover treatment of alcoholism, drug abuse or drug addiction at a facility designated by Medical Group, if prescribed by a Plan Physician and provided as a program of treatment.

**Outpatient Care**

We cover the following Services:

- Intensive outpatient programs;
- Counseling (both individual and group therapy visits);
- Medical treatment for withdrawal symptoms;
- Hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs; and
- Aftercare support visits, when provided as part of a covered program.

Your physician prescribes the appropriate type of Services for you.

**Chemical Dependency Services Exclusions**

- Inpatient treatment services are not covered.
- Services in a specialized facility, including a residential treatment facility, for alcoholism, drug abuse or drug addiction except as described above are not covered.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

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## Outpatient Prescription Drugs

The following terms, when capitalized and used in this section or in the "Schedule of Benefits" section, mean:

**Generic Drug** is a prescription drug that does not bear the trademark of a specific manufacturer. It is chemically the same as and generally costs less than a Brand Name Drug. It is a drug which is designated as a Generic Drug by us.

**Brand Name Drug** is a prescription drug that is manufactured and sold under a name or trademark by a specific drug manufacturer. It is a drug which is designated as a Brand Name Drug by us.

We cover the drugs and supplies listed below when prescribed by a Plan Physician or dentist.

You must obtain these drugs from a Kaiser Permanente Medical Center Pharmacy or at a community pharmacy designated by Health Plan.

We cover drugs for which a prescription is required by law and which are listed in the Kaiser Permanente drug formulary. Certain diabetic supplies do not require a prescription, but must still be listed in our drug formulary in order to be covered under this benefit. Each prescription refill is provided on the same basis as the original prescription. Copayments are applied up to the days supply per prescription as listed in the "Schedule of Benefits" section or the standard dispensing amount as determined by Health Plan, based on the recommendation of our Pharmacy and Therapeutics Committee.

Items covered under outpatient prescription drugs include the following:

- Drugs approved by the Food and Drug Administration (FDA)
- Drugs for which a prescription is required by law.

- Prescription drugs on the Kaiser Permanente drug formulary
- Oral medications for the treatment of diabetes
- Insulin
- Disposable needles and syringes for injecting prescribed insulin
- Glucose ketone and acetone test strips or tablets
- Oral and nasal inhalers
- Compounded preparations which must be prepared by a pharmacist
- Diaphragms
- Oral contraceptive drugs
- Time-released implantable or injectable drugs and contraceptives (including topical contraceptives). No refund is given if the implant is removed.
- Intrauterine devices
- Amino acid-modified products used to treat congenital errors of amino acid metabolism
- Postsurgical immunosuppressant outpatient drugs required as a result of a covered transplant

The standard dispensing amount for migraine medications, ophthalmic, otic and topical medications, and oral and nasal inhalers is the smallest standard package unit available. The standard dispensing amount for other drugs may have quantity limits established by our Pharmacy and Therapeutics Committee.

**Special note about our drug formulary**

The Kaiser Permanente drug formulary is a list of prescription drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is comprised of Plan Physicians and other Plan Providers, selects prescription drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The Pharmacy and Therapeutics Committee meets several times each year to consider adding and removing prescription drugs on the drug formulary.

If you request a non-formulary drug – although your Plan Physician feels there is an acceptable formulary alternative – you will be responsible for the full cost of that drug.

However, if your Plan Physician documents that:

- A non-formulary drug best treats your medical condition;
- A formulary drug has been ineffective in the treatment of your medical condition; or
- A formulary drug causes or is reasonably expected to cause a harmful reaction, then

an exception process is available to your Plan Physician. In that case, if the exception is approved, your standard prescription drug Copayment, Coinsurance and deductibles would apply. This formulary exception process does not apply to your dentist. In order to be covered at your prescription drug Copayment, Coinsurance and deductible all prescriptions written by your dentist must be included on the Kaiser Permanente drug formulary.

**Review and Authorization**

Certain prescription drugs require review and authorization prior to dispensing. Your Plan Physician must obtain this review and authorization. Failure to obtain this review and authorization will result in the drug not being covered. The list of prescription drugs requiring review and authorization is subject to periodic review and modification by our Pharmacy and Therapeutics Committee.

If you would like information about:

- whether a particular drug is included in our drug formulary
- obtaining a formulary brochure that lists the formulary drugs and provides more information about our drug formulary, or
- whether a drug requires authorization,

please call our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). You may also visit us online at www.kp.org.

**Outpatient Prescription Drugs Mail-Order Service**

We cover prescription drug mail order service. Benefits are subject to the Copayments, Coinsurance, deductibles and limits described under this Outpatient Prescription Drugs Benefit and in the “Schedule of Benefits” section.

You can order prescription refills for mail delivery three ways:

1. Online, using our Members Only website ***www.members.kp.org***. Some features, including prescription refills, require a one-time online registration. Online prescription orders must be paid for in advance by credit card;

2. Call our pharmacy mail-order line at (770) 4342008. Mail-order prescriptions must be paid for in advance by credit card; or

3. Fill out and send in your request by using one of our mail-order pharmacy envelopes. You can order a supply of mail-order pharmacy envelopes by calling our Customer Service Department, Monday thru Friday from 8:30 a.m. to 9 p.m. and Saturday and Sunday from 8 a.m. to 2 p.m. at (404) 261-2590 (locally) or 1-888-865-5813 (long distance). When you use this method of ordering, you can pay by check or credit card.

You may order up to a 90-day supply. You will be subject to the applicable Copayments, Coinsurance and deductibles – for example when you order a 90-day supply you will pay three times the Copayment you would pay for a 30-day supply. There is no shipping charge and no additional fees for mail-order prescriptions.

Please allow three to five business days for the prescription to be filled and delivered to you by mail.

Keep in mind that not all drugs are available through the mail-order service. Examples of drugs that cannot be mailed include:

- Controlled substances as determined by state and/or federal regulations;
- Medications that require special handling;
- Medications administered by or requiring observation by medical professionals;
- High cost drugs;
- Bulky items;
- Medications that require refrigeration;
- Medications requested to be mailed outside of the state of Georgia;
- Injectables; and
- Other products or dosage forms identified as safety risks.

**Outpatient Prescription Drugs Exclusions**

The following items are excluded from the outpatient prescription drug coverage, in addition to those set-forth in the general limitations and exclusions section:

- Drugs and supplies other than those listed above are not covered.
- Unless an exception is made by Health Plan, drugs not approved by the Food and Drug Administration and in general use as of March 1 of the year immediately preceding the year in which this EOC became effective or was last renewed are not covered.
- If a Service is not covered under this EOC, any drugs and supplies needed in connection with that Service are not covered.
- Immunizations and other drugs and supplies needed solely for travel are not covered.
- Durable Medical Equipment used to administer drugs is covered only as described under "Durable Medical Equipment (DME)" in this EOC.
- Administration of a drug is not covered under this benefit.
- Drugs for smoking cessation are not covered.
- Immunizing agents, biological sera, blood or blood plasma are not covered.
- Minoxidil (Rogaine) for the treatment of alopecia is not covered.
- Experimental or investigational drugs are not covered.
- Anti-wrinkle agents are not covered.
- Retin-A for individuals 26 years of age or older are not covered.
- Drugs determined by the FDA as lacking substantial evidence of effectiveness are not covered.
- Drugs and injectables used in connection with cosmetic Services are not covered.
- Packaging of prescription medications is limited to Health Plan standard packaging. Special packaging is not covered.
- Replacement of lost, stolen or damaged drugs and accessories is not covered.
- Infant formulas are not covered, except for amino acid-modified products used to treat congenital errors of amino acid metabolism.
- Drugs that shorten the duration of the common cold are not covered.
- Except for insulin, drugs available without a prescription or for which there is a nonprescription equivalent available are not covered, except those listed in the drug formulary.
- Drugs and injectables for the purpose of weight loss or the treatment of obesity are not covered, except where specifically noted to the contrary in this EOC.
- Drugs and injectables for the treatment of sexual dysfunction disorders are not covered.
- Drugs and injectables for the treatment of involuntary infertility are not covered.

- Drugs determined by the Pharmacy and Therapeutics Committee to warrant restriction to certain age groups.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

GA08HMOAB-RX 07/07 (8GBHKPPN)

## Vision Services

You are entitled to certain benefits and discounts provided at a vision location designated by Health Plan. Please refer to your *Physician Directory* for a listing of locations.

The following vision benefits and discounts are only provided at locations designated by Health Plan.

### Eye Exams

We cover eye exams from sources designated by Health Plan to determine the need for vision correction, to provide a prescription for eyeglasses, and to screen for eye diseases.

### Vision Services Exclusions

- Eye exams for the fitting of contact lenses or corrective lenses are not covered, except where specifically noted to the contrary in this EOC.
- Orthoptic (eye exercises or eye training) therapy.
- All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratotomy, and similar procedures) are not covered.
- Corrective lenses and eyeglasses are not covered, except where specifically noted to the contrary in this EOC.
- Visual training is not covered.
- Low vision aids are not covered.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

**Your Group may have purchased additional Vision Services benefits. Refer to the "Additional Benefits Purchased by Your Group" section to find out.**

GA06HMO-VSN10/05

## Chiropractic Services

We cover the Chiropractic Services listed below only for acute medically necessary treatment for a diagnosed medical condition. Services must be provided from sources designated by Health Plan. You do not need a referral from your Kaiser Permanente personal physician for the following covered chiropractic Services:

- Evaluation and management
- Routine chiropractic X-rays provided in the chiropractor's office (not to exceed 4 views)
- Chiropractic adjustments
- Appropriate therapies (e.g. hot and cold packs) not to exceed 2 per visit

Your plan may include visit limits. Refer to the "Schedule of Benefits" section at the end of this EOC for more information.

### Chiropractic Services Exclusions

- Vitamins and supplements are not covered.
- Vax-D is not covered.
- Structural supports are not covered.
- Massage therapies are not covered.
- Maintenance/preventative care is not covered.
- Non-acute medically necessary treatment is not covered.
- Acupuncture therapy is not covered.
- Physical, speech and occupational therapy are not covered, unless authorized by the Medical Group Chief of Quality Resource Management or his/her designee.
- Neurological testing is not covered, unless authorized by the Medical Group Chief of Quality Resource Management or his/her designee.
- Laboratory and pathology services are not covered.
- Chiropractic Services are covered under this benefit only when received from chiropractors designated by Health Plan.

**Copayments, Coinsurance and deductibles may apply to the benefits listed above. Refer to the "Schedule of Benefits" section for more information.**

GA07HMOAB-CHIRO 08/06

# Schedule of Benefits

## For CITIGROUP

This section summarizes:

- Copayments, Coinsurance and deductibles (if any) ;
- dependent and student age limits;
- benefit limits such as day limits, visit limits and benefit maximums.

It does not describe all the details of your benefits. To learn what is covered for each benefit (including exclusions and limitations), please refer to the identical heading in the “Benefits” and “Additional Benefits” sections and to the General Exclusions Limitations and Reimbursement of Health Plan and Coordination of Benefits” section of the EOC.

**Dependent and Student Age limits**

The Dependent age limit as described in the “Premium, Eligibility, Enrollment and Effective Date” section of the EOC is 19. An unmarried dependent child will continue to be eligible until the end of the month in which the dependent child reaches this age.

The Dependent student age limit as described in the “Premium, Eligibility, Enrollment and Effective Date” section of the EOC is 26. A full-time student in an accredited college or school will continue to be eligible until the end of the month in which the dependent student reaches this age.

**For a complete understanding of the benefits, exclusions and limitations applicable to your coverage, it is important to read your EOC in conjunction with this Schedule of Benefits.** Here is some information to keep in mind as you read the Schedule of Benefits.

Some benefits under this EOC have annual limitations such as dollar, day or visit limitations. Benefits that are subject to an annual maximum are shown in the following “Schedule of Benefits” section of this EOC. All annual maximums are calculated based upon a calendar year. If you enrolled under this EOC at any point after the first of the year, any covered Services that you previously incurred in the same calendar year, under a prior EOC from Health Plan, shall carry-forward and count toward the annual maximums shown in this EOC.

The annual dollar, day and visit limits, deductibles and Out-of-Pocket Maximums are based on calendar year. Copayments, deductibles or Coinsurance for Services are due at the time of your visit. For items ordered in advance, you pay the deductible, Copayment, or Coinsurance in effect on the order date. Note: We reserve the right to reschedule non-urgent care if you do not pay at the time of your visit. In some cases, we may agree to bill you for your deductible, Copayment, or Coinsurance. If we agree to bill you, or you don't pay at the time of your visit, you will be required to pay a $20 service fee for each bill sent for unpaid Services.

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| Maximum Benefit While Covered<br>(Some specific benefits may have limitations) | Unlimited |

### Covered Services

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| **OFFICE SERVICES** | |
| Primary care visits (including laboratory Services and X-rays for adult medicine, internal medicine, family practice, pediatrics) | $15 Copayment |
| Specialty care visits (including laboratory Services and X-rays) | $25 Copayment |
| High tech radiology Services (including CT, PET, MRI, myelograms, and nuclear medicine scans) | $25 Copayment |
| Allergy treatment serum | $50 Copayment every 6 months for maintenance serum |
| Injection visits | $10 Copayment |
| **Preventive Visits and Services** | |
| Well-child care visits<br>(up to age 24 months) | Plan Pays 100% |
| Annual physical exams for children age 2 and above and routine physical exams for adults<br>Limited to one exam every 12 months | $15 Copayment |
| Annual well-woman exams<br>Limited to one exam every 12 months | $15 Copayment |
| Preventive care screening services and procedures (including pap smears, mammograms and prostate specific antigen (PSA) tests) | Plan Pays 100% |
| **Maternity Care** | |
| Routine prenatal visits and delivery (obstetrician, nurse midwife, OB nurse practitioner) and first postpartum visit | Plan Pays 100% |
| All other visits during pregnancy, (including nutritionists,genetics counselors and perinatologists) | $25 Copayment |
| Maternity inpatient hospital Services | $500 Copayment per admission |
| Physician/Professional charges | Plan Pays 100% |
| **OUTPATIENT SERVICES** | |
| High tech radiology Services (including CT, PET, MRI, myelograms, and nuclear medicine scans) | $250 Copayment |
| Outpatient surgery (including professional charges) | $250 Copayment |
| Outpatient facility/hospital charges (including professional charges, laboratory Services and X-rays) | $250 Copayment |
| Chemotherapy and other visits to infusion centers | $25 Copayment |
| Radiation therapy | $25 Copayment |
| **Physical, Occupational, and Speech Therapy, and Cardiac Rehabilitation** | |
| Physical therapy visits | $25 Copayment<br>Combined physical therapy and occupational therapy. Up to 20 visits per Year. |

## Covered Services

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| Occupational therapy visits | $25 Copayment<br>Combined physical therapy and occupational therapy. Up to 20 visits per Year. |
| Speech therapy visits | $25 Copayment<br>Up to 20 visits per Year. |
| Cardiac rehabilitation, up to 12 weeks or 36 visits per Year | $25 Copayment |
| **Dialysis Care** | |
| Dialysis | $25 Copayment |
| **EMERGENCY SERVICES** | |
| Emergency room visits<br><br>NOTE:<br>Non-emergency use of the emergency room is not covered | $75 Copayment (If you are admitted to the hospital as an inpatient, the charge will be waived) |
| Ambulance Services | $75 Copayment per trip |
| **After Hours Urgent Care** | |
| After hours urgent care Services | $30 Copayment |
| **INPATIENT SERVICES** | |
| **Hospital Inpatient Care** | |
| Inpatient hospital (including medical detoxification) | $500 Copayment per admission |
| Physician/Professional charges | Plan Pays 100% |
| **MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES** | |
| **Outpatient Mental Health** | |
| Outpatient individual therapy<br>Up to 40 visits per Year combined with group therapy | $25 Copayment |
| Outpatient group therapy<br>Combined outpatient group therapy and outpatient individual therapy, up to 40 visits per Year. | $12 Copayment |
| Outpatient Mental Health visits for the purpose of monitoring drug therapy | $15 Copayment |
| **Inpatient Mental Health** | |
| Inpatient mental health facility<br>Up to 30 days per Year | $500 Copayment per admission |
| Physician/Professional charges | Plan Pays 100% |
| **Outpatient Chemical Dependency Treatment** | |
| Outpatient therapy<br>Up to 40 visits per Year, combined with outpatient group therapy (whether performed in a physician's office or outpatient facility/hospital) | $25 Copayment |
| **PHARMACY SERVICES** | |
| **Outpatient Prescription Drugs** | |
| Up to the lesser of a 30 day supply or the standard prescription amount | |
| Copayments and Coinsurance for Outpatient Prescription Drugs do not count toward satisfaction of the Annual Deductible, if any, or the Copayment or Coinsurance Out-of-Pocket Maximums. | |
| Generic Drugs | $10 Copayment at Kaiser Permanente Medical Center Pharmacies and $16 Copayment at designated community pharmacies. |

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| Brand Name Drugs | $20 Copayment at Kaiser Permanente Medical Center Pharmacies and $26 Copayment at designated community pharmacies. |
| Time-released implantable or injectable drugs and contraceptives | You pay the prescription drug Copayment multiplied by the number of months the drug is effective, but not more than $200. |
| Intrauterine devices | $50 Copayment per device |
| **OTHER SERVICES** | |
| **Skilled Nursing Facility Care** | |
| Room and board, skilled nursing Services (including Physician/Professional charges)<br>Up to 100 days per Year | Plan Pays 100% |
| **Home Health Care** | |
| Covered Services<br>Up to 120 visits per Year | Plan Pays 100% |
| **Hospice Care** | |
| In the Service Area, benefits for hospice care instead of traditional Services | Plan Pays 100% |
| **Dental Care** | |
| Dental Services and appliances for accidental bodily injury to sound and natural teeth | Plan Pays 50%<br>$500 Benefit Maximum per accident |
| Non-surgical dental treatment, including splints and appliances, for Temporomandibular Joint Dysfunction | Plan Pays 50% |
| **Durable Medical Equipment (DME)** | |
| Covered equipment or devices | Plan Pays 50% |
| **Prosthetics and Orthotics** | |
| Covered devices | Plan Pays 50% |
| **Infertility Services** | |
| Diagnosis Services | Refer to the Office Services, Outpatient Services and Inpatient Services sections of this Schedule of Benefits for payment information. |
| **Vision Services** | |
| Screening for eye disease | $25 Copayment |
| Eye exams for corrective lenses<br>(Does not include fitting for cosmetic contact lenses) | $25 Copayment |
| **Chiropractic Services** | |
| Up to 20 visits per Year | $25 Copayment |