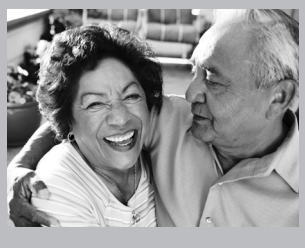


guide to
YOUR BENEFITS AND SERVICES

kaiserpermanente.org

Your 2012

Group Plan
Evidence of Coverage

HEALTH PLAN
NCQA
ACCREDITATION
EXCELLENT

KAISER PERMANENTE®
Georgia Region

BOOK 12H27

150*305

Welcome to Kaiser Permanente!

We are pleased that you have selected us for your health care. 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.

Please take a few minutes to get to know us by reviewing this Evidence of Coverage (EOC). This EOC along with your I.D. card(s) and the Member Handbook gives you important information about your plan and about accessing care at Kaiser Permanente. Your I.D. card(s) and Member Handbook will be mailed to you separately.

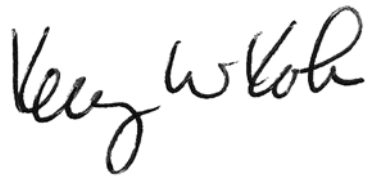
The Group Agreement plus this EOC make up the entire contract between Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan) and your Group. Your EOC is customized to inform you of what services are specifically available to you and what your out-of-pocket expenses will be. For a summary of this information, please refer to the "Schedule of Benefits" section of this EOC. It is important that you familiarize yourself with your coverage by reading this EOC completely, so that you can take full advantage of your Health Plan benefits.

This EOC replaces all information that you may have received in previous EOCs from us. It is important that you use only the latest EOC as your reference because your benefits may have changed. 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 Premiums or accepts the changes after they have gone into effect, your Group will be considered to have consented to the changes. This consent will also apply to you and to your enrolled Dependents.

In this EOC, you and your covered Dependents are sometimes referred to as "you" or "your". Health Plan is sometimes referred to as "we", "our", or "us". Further, some capitalized terms may have a special meaning in this EOC; please see the "Definitions" section for terms you should know.

If you have questions about your Kaiser Permanente benefits or accessing care, please call our Member Services Department for assistance, Monday through Friday from 7 a.m. to 7 p.m. EST at (404) 261-2590 or 1-888-865-5813. When you are ready to schedule an appointment, please call our appointment center at (404) 365-0966.

Sincerely,



Kerry W. Kohnen

President

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Introduction

About Kaiser Permanente's HMO Plan

You have selected the Kaiser Permanente HMO Plan.

For benefits provided under any other Health Plan program, refer to that plan's EOC.

Kaiser Foundation Health Plan of Georgia, Inc., is sometimes referred to as "Health Plan", "we", "our", or "us"

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 Plan Physician.

You must receive all Services from Plan Providers within our Service Area, except as described under the following headings:

- Emergency Services;
- Getting a Referral; and
- Visiting Other Regions.

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.

Definitions

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

Affiliated Community Physician: A primary care or specialist physician that contracts with Medical Group to provide covered Services to Members under this EOC.

Annual Deductible: The amount of Eligible Charges you must pay for certain covered Services each Year before we pay any amount for those 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.

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.

Under this provision, covered expenses that were applied to your Annual Deductible and Out of Pocket Maximum under the prior group coverage will be credited toward satisfaction of the Annual Deductible, as applicable under this group coverage, if:

- You were covered under your prior group coverage on the day before the effective date of this group coverage;
- You incurred the covered expenses during the 90 days prior to the effective date of this group coverage;

- 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.

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: The maximum amount of Coinsurance you and/or your Family must pay each Year for certain covered Services. Once the Coinsurance Out-of-Pocket Maximum is reached, we will pay 100% of further Eligible Charges incurred by you and/or your Family for those covered Services during the remainder of the Year. Keep your receipts to verify the Coinsurance you and/or your Family have paid.

The following Eligible Charges do not apply to the out of pocket maximum:

- All Copayments
- Dental Services
- Benefits with an allowance

Copayment: The pre-determined dollar amount that you, or a Dependent, must pay at the time certain covered Services are received from Plan Providers or Plan Physicians. 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: The maximum amount of Copayments you, or a Dependent, must pay each Year for covered Services provided by Plan Providers or Plan Physicians. We will pay 100% of further eligible Charges incurred by you or your Family for certain covered Services during the remainder of the Year. Keep your receipts to verify the Copayments you or your Family have paid.

Copayments for the Services listed below do not apply to your Copayment Out-of-Pocket Maximum. Not all Services listed below may be covered under your specific plan. Please refer to the "Schedule of Benefits" section for additional information.

- Chiropractic care
- Durable medical equipment
- Dental care
- Hearing aid
- Infertility treatment Services
- Optical exams or hardware
- Prosthetics and orthotics
- Prescription drugs
- Continuing or follow-up treatment outside the Service Area
- Morbid Obesity Services

Cost Sharing: The amount you are required to pay for covered Service, for example: the Annual Deductible, Copayment, or Coinsurance.

Dependent: Any person:

- Who meets the dependent eligibility requirements described in the "Premium, Eligibility, Enrollment and Effective Date" section;
- Who enrolls under this plan; and
- For whom we have received the appropriate Premium.

Designated Specialist Provider: A physician, practitioner, hospital or other licensed provider, who may be a Plan Provider that can provide Services to Members only after receiving Prior Authorization as described in Authorization for Services under the "Benefits" section.

Eligible Charges: Means the following:

- For Services provided by Health Plan or Medical Group, the amount in the Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members;
- For Services received from Plan Providers or other contracted providers, the amount the provider has agreed to accept as payment:
- 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
- The lesser of Health Plan's reasonable and customary fee or billed charges for Services received from non-contracted providers.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

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

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, the Medically Necessary Services required to Stabilize the patient. Once your condition is Stabilized, covered Services that you receive are Post Stabilization Care and not Emergency Services.

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.

Kaiser Permanente: The direct service health care program conducted by Health Plan and Medical Group, or a related organization.

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 in, Medical Group.

Medically Necessary: Our determination that the Service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and/or your provider; and, (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, "generally accepted standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the relevant clinical area or areas within the Kaiser Permanente; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a service is Medically Necessary. You may appeal our decision as set forth in

the “Getting Assistance, Filing Claims, and Dispute Resolution” Section. The fact that a Plan Provider has prescribed, recommended, or approved a service, item or supply does not, in itself, make it Medically Necessary and, therefore, a covered Service.

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

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

Plan: Kaiser Foundation Health Plan of Georgia, Inc.

Plan Hospital: A hospital that contracts with Kaiser Foundation Hospitals to provide hospital Services to members.

Plan Physician: Any Medical Group Physician or Affiliated Community Physician, except Designated Specialist Providers.

Plan Provider: A Plan Physician, practitioner, Medical Center, medical office, Plan Hospital, or other licensed provider of Services, except for Designated Specialist Providers, with whom the Medical Group or Health Plan contracts to provide Services to Members, 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.

Prior Authorization: Our determination that the proposed Service is Medically Necessary pursuant to the Quality Resource Management Program in advance of your appointment or admission.

Service Area: The geographic in which Health Plan is licensed as an HMO including the following:

Atlanta Metro 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.

Athens Service Area: Clarke, Madison, Oconee, and Oglethorpe.

Columbus Service Area: Chattahoochee, Harris, Marion and Muscogee.

Macon Service Area: Bibb, Bleckley, Crawford, Houston, Jones, Laurens, Monroe, Peach, Pulaski, and Twiggs.

Savannah Service Area: Bryan, Bulloch, Chatham, Effingham, Evans, and Liberty.

Services: Any treatment, therapeutic or diagnostic procedure, drug, equipment or device as described in the “Benefits” section. When a service is excluded, all services that are associated with the excluded service even if they 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.

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

Subscriber: A 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.

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.

Who is Eligible

Subscribers

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

- are an employee of your Group; and work for your Group a specified number of hours as determined by your Group and approved by Health Plan, or are on paid leave through your employer Group;
- are 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);
- are a Retiree of the Group, as approved by Health Plan;
- are not employed as a temporary, seasonal or substitute basis;
- reside or work in the Service Area at the time of enrollment, unless your employer permits employees who either live or work in the Service Area to enroll.

Dependents

If you are a Subscriber and if your Group allows enrollment of Dependents, the following persons may be eligible to enroll as your Dependents:

- Your Spouse
    - Your or your Spouse's children (including adopted children or children placed with you for adoption) who are under Dependent limiting age shown in the “Schedule of Benefits” section.
- Other dependent persons (but not including foster children), who meet all of the following requirements:
    - They are under the Dependent limiting age shown in the “Schedule of Benefits” section;
    - You or your Spouse is the child’s court-appointed guardian (or was when the person reached age 18).
- Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible as a disabled dependent if they meet all the following requirements:
        - They are incapable of self-sustaining employment because of physically or mentally-disabling injury, illness, or condition that occurred prior to reaching the Dependent limiting age as shown in the “Schedule of Benefits” section.
        - They receive substantially all of their support and maintenance from you or your Spouse;
        - You give us proof of incapacity and dependency annually if we request it.

Ineligible persons

The following persons are not entitled to enroll in Health Plan:

- Any Family member who has ever had his or her membership with Health Plan terminated for any of the reasons listed in the “Termination or Rescission of Membership” section. If so, neither you nor any member of your Family may enroll.
- Persons eligible for any part of Medicare as primary coverage may not enroll under this plan. Please call our Senior Advantage Member Services Department, seven days a week, from 8 a.m. to 8 p.m., at (404) 233-3700 (local) or 1-800-232-4404 (long distance) or 1-800-255-0056 (TTY).

Loss of Eligibility

Subscriber's Relocation from the Service Area

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

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 reaches the applicable age limit or no longer meets all of the other requirements of this plan for Dependent status.

NOTE: If you lose eligibility for group coverage you may be eligible for Kaiser Permanente Conversion or Continuation coverage. Please call our Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance).

Enrollment and Effective Date of Coverage

Initial Enrollment

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.

If you or your Dependents do not enroll when first eligible you must wait until the next open enrollment period as determined by your Group (see "Special Enrollments" section).

Special Enrollments

Special Enrollment due to newly eligible Dependents:

- Newly eligible Dependents includes:
  - New Spouse;
  - New step children;
  - Newborns
  - Newly adopted children, including children placed with you for adoption;
  - Children for whom you assume legal guardianship; and
  - Children for whom you have a court order to provide 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 a Dependent becomes newly eligible.
- The membership effective date for the Dependent (and, if applicable, the new Subscriber) will be:
  - For newborn children, the date 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, the effective date of coverage is from either the date of legal placement for adoption or the final adoption decree, whichever is earlier, but the child must be enrolled within 31 days of that date for membership to continue.
  - For other than newborn and newly adopted children, the effective date of coverage for new Dependents is the first of the month following the date of enrollment application.

Note: In order to be covered, all Services for any newborn child 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, except the time-frame is 60 days if you are requesting enrollment for Medicaid coverage or Child Health Insurance Program 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. For example, this loss of eligibility may be due to legal separation or divorce, reaching the Dependent limiting age shown in the "Schedule of Benefits" section, or the Subscriber's death, termination of employment, or reduction in hours of employment.
- Loss of eligibility of Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause.
- The enrolling person(s) have reached a lifetime maximum on all benefits under the other coverage.
- Loss of coverage as a result of moving out of the other plan's service area.

NOTE: 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.

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 eligibility for premium assistance under Medicaid or CHIP

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Health Plan approved enrollment or change of enrollment application to your Group within 60 days after the Subscriber or Dependent is determined eligible for premium assistance. The effective ate of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is not later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

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.

As a Member, you are selecting Kaiser Permanente to provide and arrange your health care. The Services described in this EOC are covered ONLY if they are benefits provided, prescribed or directed by a Plan Physician and are Medically Necessary. Some will also require Prior Authorization by Health Plan. When you receive medical services for which you do not have Prior Authorization or that you receive from non-Plan Physicians or from non-Plan Facilities that have not been provided, prescribed or directed by a Plan Physician, we will not pay for them except in an Emergency. Charges for these medical services will be your financial responsibility. You must receive all Services from Plan Providers, except as described under the following headings:

- Emergency Services,
- Getting a Referral
- Visiting Other Regions

To receive covered Services, you must be enrolled in the Health Plan on the date on which you receive each covered Service. Anyone who is not a Member will be billed for any Services we provide in the amount of the applicable Eligible Charge. Claims for covered Services will be denied if you are not a Member on the date of which the Services are rendered.

Covered Services for Members are provided or directed Medical Group and by Affiliated Community Physicians**.** Medical Group Physicians provide Services at Kaiser Permanente 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 Designated Specialist Physicians who are specialists for Services that are Medically Necessary.

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.

Choosing your Personal Physician

Your Kaiser Permanente personal physician plays an important role in coordinating your health care needs, including Plan Hospital stays and referrals to other Plan Providers. We encourage you to choose a Medical Group Physician or an Affiliated Community Physician as your personal physician when you enroll.

You and each member of your family will need to select a personal physician upon enrollment. You may choose any Plan Physician who is available to accept you. If you do not select a personal physician upon enrollment, we will assign a Medical Group Physician or an Affiliated Community Physician based upon your home address. That Plan Physician will be listed in our records as your personal physician until you select your personal physician and inform us of your decision.

The following types of Plan Physicians may be chosen as a personal physician:

- Family Practice
- Internal Medicine
- General Practice, or
- Pediatrics/Adolescent Medicine

Adults should select an internal medicine, general practice or family practice physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Parents may also choose a 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 that such Plan Physicians treat children. To learn how to choose or change a personal physician, please call our Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance). You can access our Web site at ***www.kp.org*** to choose a personal physician or to view a current listing of physicians.

Changing your Personal Physician

You may change your Kaiser Permanente personal physician as often as you wish using one of the options listed below. Make sure to have your Kaiser Permanente health record number available.

- Call our Member Service Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance).
- Notify your health care team while visiting one of our Medical Centers.
- Access our website at www.kp.org.

Getting a Referral

If your Kaiser Permanente personal physician determines that you require covered Services from a specialist, you will be referred to a Plan Provider.

You are required to obtain a referral from your Kaiser Permanente personal physician prior to receiving specialty care Services, except as noted, in the Self-Referral section below. Your Kaiser Permanente personal physician will refer you to other Plan Physicians when you need covered Services from other Plan Providers and will obtain Prior Authorization for covered Services when required under Health Plan's Quality Resource Management Program. If you request Services which are not Medically Necessary or exceed the specific Services (for example, are beyond the level of care) authorized by us, then you will be responsible for all charges associated with these unauthorized Services, and Health Plan will not pay for such Services.

If your Kaiser Permanente personal physician decides that you require covered Services not available from Plan Physicians, he or she will refer you to a non-Plan Provider inside or outside our Service Area. This referral must also be approved prior to Services being rendered. You must have an approved written referral to the non-Plan Provider in order for us to cover the Services. You will be responsible for the same Copayments, Coinsurance and/or deductible amounts that would be owed by you if such approved referral Service was being provided by a Plan Provider.

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

Self-Referral

You do not need a referral from your Kaiser Permanente personal physician for appointments with dermatologists, psychiatrists, behavioral health specialists, optometrists, and ophthalmologists and any specialist in the Medical Group. Your personal physician works with specific specialty groups and may recommend a specialist to you. You may also choose one of the self-referral specialists.

Female Members do not need a referral or Prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Physician who specializes in obstetrics or gynecology. The Plan Physician, however, may have to get Prior Authorization for certain Services.

Hospital Care

Hospital Services, other than Emergency Services, require Prior Authorization and will be arranged by your Plan Physician, and except when we authorize otherwise, will generally be provided at a Plan Hospital that we designate. We may direct that you receive covered hospital Services at a particular Plan Hospital so that we may better coordinate your care using Medical Group Plan Physicians and our electronic medical record system.

Plan Hospitals are listed in your Physician Directory. This listing is subject to change during the Year.

Getting the Care You Need

Emergency Services and Urgent Care

Emergency Services

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.

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need Prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services that you receive from Plan Providers or non-Plan Providers anywhere in the world, as long as the Services would have been covered under the "Benefits" section (subject to the "General Exclusions, Limitations, and Reimbursement of Health Plan, and Coordination of Benefits (COB)" section) if you had received them from Plan Providers. Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Stabilized. We cover Post-Stabilization Care from a non-Plan Provider, including inpatient care at a non-Plan Hospital only if we provide Prior Authorization for the Services or if otherwise required by applicable law.

To request Prior Authorization for Post-Stabilization Care from a non-Plan Provider, you must call us at (404) 365-0966 (local) or 1 (800) 611-1811 (long distance or the notification telephone number on your Kaiser Permanente ID card ***before*** you receive the care if it is reasonably possible to do so (otherwise call us as soon as reasonably possible). After we are notified, we will discuss your condition with the non-Plan Provider. If we decide that you require Post-Stabilization Care and that this care would be covered if you received it from a Plan Provider, we will authorize your care from the non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Skilled Nursing Facility, or designated non-Plan Provider provide your care, we may authorize special transportation Services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

We understand that extraordinary circumstances can delay your ability to call us to request Prior Authorization for Post-Stabilization Care from a non–Plan Provider, for example, if a young child is without a parent or guardian present, or you are unconscious. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for you. We will not pay for any Services you receive from non–Plan Providers after your Emergency Medical Condition is Stabilized unless you obtain Prior Authorization, so if you don't call as soon as reasonably possible, you will be financially responsible for this care.]

Cost Sharing

The Cost Sharing for covered Emergency Services and Post-Stabilization Care is the Cost Sharing required for Services provided by Plan Providers as described under “Emergency Services” in the “Schedule of Benefits” sections of this EOC.

Please refer to “Schedule of Benefits” for Cost Sharing for emergency department visits. The Cost Sharing for other covered Emergency Services and Post-Stabilization Care is the Cost Sharing that you would pay if the Services were not Emergency Services or Post-Stabilization Care. For example, if you are admitted as an inpatient to a non-Plan Hospital for Post-Stabilization Care and we give Prior Authorization for that care, your Cost Sharing would be the Cost Sharing shown under “Hospital Inpatient Care” in the “Schedule of Benefits” section of this EOC.

Services not covered under this “Emergency Services” section

Coverage for covered Services that are not Emergency Services or Post-stabilization care as described in this “Emergency Services” section will be covered as described under other sections of this EOC.

Payment and Reimbursement

If you receive Emergency Services or Post-Stabilization Care from a non-Plan Provider as described in this “Emergency Services and Urgent Care” section, or emergency ambulance Services described under ”Ambulance Services” in the “Benefits” section or “Schedule of Benefits” section, you will have to pay the non-Plan Provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a non-Plan Provider as part of covered Emergency Services or Post-Stabilization Care even if you receive the Services from a Plan Provider.

We will reduce any payment we make to you or the non-Plan Provider by applicable Cost Sharing.]

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical condition.

During Normal Business Hours

If you think you may need Urgent Care during normal business hours call your Plan Physician’s office or our Health Line is available 24 hours a day, 7 days a week (404) 365-0966 (local) or 1-800-611-1811 (long distance).

After Normal Business Hours

If you think you may need Urgent Care after normal business hours call our Health Line. We cover Urgent Care Services at our designated **Kaiser Permanente After-Hours Care Centers**. Services must be obtained at **Kaiser Permanente After-Hours Care Centers** or at the Affiliated Community After-Hours Urgent Care Centers designated by Health Plan.

After-Hours Urgent Care

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 (local), or 1-800-611-1811 (long distance).

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.

After-Hours Urgent Care is available at the **Kaiser Permanente After-Hours Care Centers** or the Affiliated Community After-Hours Urgent Care Centers listed in your Physician Directory.

If you have selected an Affiliated Community Physician, you may call your physician’s office during regular office hours or you may call our Health Line that is available 24 hours a day, 7 days a week.

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

Routine Care Appointments

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 (local), 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.

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.

Visiting Other Regions

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

The 90-day limit on visiting member care does not apply to Members who attend an accredited college or accredited vocational school. The service areas and facilities where you may obtain visiting member care may change at any time without notice.

Please call our Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance) to receive more information about our visiting member program, including facility locations in the Service Area of another Region, and to request a copy of the visiting member brochure.

Region, as used in this section, means a Kaiser Foundation Health Plan organization or allied plan that conducts a direct service health care program. For information about Region locations in the District of Columbia and parts of Southern and Northern California, Colorado, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington call our Member Services Department.

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 Member Services Department or the Member Services 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
- 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 Member Services Department at (404) 261-2590 (local) 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 Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance).

Note: Neither Health Plan nor Plan 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 Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) 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). Your PHI is individually identifiable information about your health, health care services you receive, or payment for your health care.

We may use or disclose your PHI for treatment, payment, health research, and health care operations purposes, such as measuring the quality of 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 Member Services 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*, which provides additional information about our privacy practices and your rights regarding your PHI.

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 Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) 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.

1. **Services that are not Medically Necessary**

   Unless otherwise required by law, we decide if a Service is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in the Getting Assistance, Filing Claims, and Disputes Section of this EOC.

2. **Alternative Services**

   We do not cover Alternative Services, including but not limited to: Musculoskeletal therapy involving manual manipulation of the spine (except as a limited benefit described elsewhere in this EOC), Vax-D, massage therapies, acupuncture therapy, vitamins and supplements.

3. **Cord Blood**

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

4. **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, school, sports, camp 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 (a) having custody of a Member or (b) overseeing or monitoring Member's activities (such as probation, home detention or participation in an outpatient program), unless the Services are covered Emergency Services as described in this EOC.
   - Services provided, ordered, or arranged by a mental health instituition where the Member is confined or resident, unless the Services are covered Emergency Services as described in this EOC.

5. **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 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.

6. **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.

7. **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.

8. **Employer requirements**

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

9. **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.

10. **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.

11. **Government agencies**

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

12. **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).

13. **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.

14. **Military services**

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

15. **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.

16. **Personal comfort items**

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

17. **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.

18. **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.

19. **Services while committing a Felony**

    Services, except for Emergency Services, for the treatment of injuries received while committing a felony.

20. **Services for the Treatment of Disease or Injury Resulting From a War**

    Services for the treatment of disease or injury resulting from a war or act of war, declared or undeclared are not covered.

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

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

22. **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.

23. **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.

24. **Sexual reassignment**

    All Services and drugs related to sexual reassignment.

25. **Services that exceed the Health Plan’s reasonable and customary fee**

    Charges from non-Plan Providers that exceed our reasonable and customary fee are not covered.

26. **Transportation and lodging expenses**

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

27. **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.

Limitations

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 or alleged to be caused by Other Parties.

Preventive Services

Preventive Services are described under “Preventive Visits and Services’’ in our “Benefits” section and are limited to as described therein. There is no Cost Sharing for Preventive Services as described under “Preventive Visits and Services” in our “Benefits” section. However, Cost Sharing will apply if non-Preventive Services are provided during a scheduled preventive visit.

Excess Coverage Provision

This coverage pays for Eligible Charges after any group health plan which is primary 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 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 Non-Plan 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 shall be 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.

Medicare law may apply with respect to services covered by 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 the secondary 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 subject to the terms and conditions of this EOC. 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 Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) 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 Member Services 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 request Services, 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 the manner in which Services are provided by 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 provided by physicians or other pro-

viders 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 Member Services at (404) 261-2590 (local) or 1-888-865-5813 (long distance). A Member Services Representative will be glad to help.

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

- If you are dissatisfied with the way your complaint has been handled, you may request a second review of your complaint. To request a second review, contact the Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance). The Member Services Department will assist you with submitting any additional information related to the second review of your complaint. The Member Relations Department will respond to your request within 14 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 complain.

Claims and Appeals Procedures

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

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

- A **claim** is a request for us to:
    - provide or pay for a Service that you have not received (pre-service claim),
    - continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
    - pay for a Service that you have already received (post-service claim).
- An **appeal** is a request for us to review our initial adverse benefit determination.
- An **adverse benefit determination** is our decision to do any of the following:
    - deny your claim, in whole or in part,
    - terminate your membership retroactively except as the result of non-payment of premiums (also known as rescission), or
    - uphold our previous adverse benefit determination when you appeal.

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

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure (as described below in this “Claims and Appeal Procedures” section) for your claim before you can request external review or seek judicial relief.

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

Language and Translation Assistance

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then your notice of adverse benefit determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request language assistance with your claim and/or appeal by calling Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance).

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then you may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request translation of the notice by calling our Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance).

Appointing a Representative

If you would like someone to act on your behalf regarding your claim or appeal, you may appoint an authorized representative. You must make this appointment in writing. Please send your representative's name, address and telephone contact information to our Appeals Department at the address shown below. You must pay the cost of anyone you hire to represent or help you.

Appeals Department
Nine Piedmont Center
3495 Piedmont Road, N.E.
Atlanta, GA 30305-1736

Help with Your Claim and/or Appeal

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
800-656-2298

Reviewing Information Regarding Your Claim

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact our Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance).

Providing Additional Information Regarding Your Claim

When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to our Appeals Department at the address shown below.

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

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to our Appeals Department at the address shown below. To arrange to give testimony by telephone, you should contact our Appeals Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 364-4862.

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

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

Sharing Additional Information That We Collect

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

Internal Claims and Appeals Procedures

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

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

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

Pre-service claims and appeals. Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized or precertified in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call Member Services at (404) 261-2590 (local) or 1-888-865-5813 (long distance).

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

- **Pre-service claim**

  - Tell Health Plan in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You may call our Member Services Department at (404) 261-2590 (local) or 1-888-865-5813 (long distance), or mail or deliver a letter to:

    Kaiser Permanente
    Quality Resource Management Department
    Nine Piedmont Center
    3495 Piedmont Road, NE
    Atlanta, GA 30305-1736

  - If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting.

  - We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 day period. If we tell you we need more information, we will ask you for the information within the initial15 day decision period, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If

we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

- We will send written notice of our decision to you and, if applicable to your provider.

- If your pre-service claim was considered on an urgent basis, we will notify you of our decision orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will wend you written confirmation within 3 days after that.

- If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

- **Non-urgent pre-service appeal**

  - Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your 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

  - We will review your appeal and send you a written decision within 30 days after we receive your appeal.

  - If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

- **Urgent pre-service appeal**

  - Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must submit your appeal orally, in person or by mail. Your 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

  - When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Claims and Appeals Procedures” section), if our internal appeal decision is not in your favor.

- We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat you appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent claims or appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting.

- We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within 3 days after that.

- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Concurrent Care Claims and Appeals. Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call Member Services at (404) 261-2590 (local) or 1-888-865-5813 (long distance).

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

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

- **Concurrent care claim**

  - Tell us in writing or orally that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must call, mail or deliver your claim to us. You may call Member Services at (404) 261-2590 (local) or 1-888-865-5813 (long distance), or mail or deliver a letter to:

    Kaiser Permanente
    Quality Resource Management Department
    Nine Piedmont Center
    3495 Piedmont Road, NE
    Atlanta, GA 30305-1736

  - If you want us to consider your claim on an urgent basis and your contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment.

  - We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your claim, we will make our decision but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 day decision period ends. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days

to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe we gave you for sending the additional information.

- We will send written notice of our decision to you and, if applicable to your provider.

- If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within 3 days after receiving your claim.

- If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

- **Non-urgent concurrent care appeal**

  - Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must send your appeal to our Appeals Department at the address shown below or, call our Appeals Department at (404) 364-4862.

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

  - We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

  - If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

- **Urgent concurrent care appeal**

  - Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must send your appeal to our Appeals Department at the address shown below or, call our Appeals Department at (404) 364-4862.

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

- When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Claims and Appeals Procedures" section).

- We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat you appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment.

- We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within 3 days after that.

- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

Post-Service Claims and Appeals. Post-service claims are requests that we for pay for Services you already received, including claims for non-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call Claims Customer Service at (404) 261-2825.

Here are the procedures for filing a post-service claim and a post-service appeal:

- **Post-service claim**

  - Within 12 months after the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. You must either mail your claim to:

    Kaiser Permanente
    Claims Administration
    P.O. Box 190849
    Atlanta, Georgia 31119-0849

  Or, you can fax your claim to *telephone number*.

  - We will not accept or pay for claims received from you after 12 months from the date of Services.

  - We will review your claim, and if we have all the information we need we will send you a written decision within 15 business days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim. If we tell you we need more information, we will ask you for the information before the end of the initial 30 day decision period ends, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

  - If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

- **Post-service appeal**

    - Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents. Your request and the supporting documents constitute your appeal. Your may call the Appeals Department at (404) 364-4862, or mail or deliver a letter to the address shown below:

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

    - We will review your appeal and send you a written decision within 60 days after we receive your appeal.

    - If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of retroactive membership termination (rescission). We may terminate your membership retroactively (see the "Termination or Rescission of Membership" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call the Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance).

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

- **Appeal of retroactive membership termination**

    - Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing or orally that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. Your may call the Appeals Department at (404) 364-4862, or mail or deliver a letter to the address shown below:

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

    - We will review your appeal and send you a written decision within 60 days after we receive your appeal.

    - If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

External Review

If you are dissatisfied with our final internal adverse benefit determination, you may have a right to request an external review by an independent third-party.

- Within four months after the date on which you receive our final internal adverse benefit determination, send your written request for external review to:

  Federal External Reviewer
  U.S. Office of Personnel Management
  P.O. Box 791
  Washington, D.C. 20044.

  Or, you may fax your request to 202-606-0036 or send it electronically to DisputedClaim@opm.gov. If you have any questions or concerns during the external review process, you may call toll free 877-549-8152.

- You will be provided a Privacy Act Statement that must accompany your written request for external review. We will provide a copy of it to you with our final internal adverse benefit determination. If you need another copy you may request one from us by calling *insert telephone number* or you can download a copy at http://www.hhs.gov/ociio/regulations/consumerappeals/index.html.

- You may submit additional information to the external reviewer by sending it to the mailing address for the Federal External Review set forth above. Please note that any additional information that you submit will be shared with us so that we may reconsider our final internal adverse benefit determination.

- The federal external reviewer will first determine whether you are entitled to external review and will notify you and us in writing if you are not eligible for external appeal. The federal external review will then all of the information and documents timely received *de novo* and will provide written notice of a final external review decision as soon as possible and no later than 45 days after the federal external reviewer receives your request for external review. This written notice will be sent to you and us.

- You may make a written or oral request for an expedited external review if (1) the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize the claimant's ability to regain maximum function but only when you have also filed a timely request for an expedited internal appeal related to your urgent pre-service or concurrent care claim, or (2) you have received our final internal adverse benefit determination and you have a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the your life or health or if the final internal adverse benefit determination concerns an admission, availability of care, continued state or health care supply or service for which you have received services, but have not been discharged from a facility. If the external reviewer determines that you are not eligible for expedited external review, then the external reviewer will notify you and us as soon as possible. The external reviewer must provide notice of the final external review decision as soon as the medical circumstances require but no later than 72 hours after the external review receives your request for expedited external review unless you are in an ongoing course of treatment for that condition and then the external review decision will be provided within 24 hours. This notice may be provided orally but must be followed in writing to you and us within 48 hours of the oral notification.

- If the external reviewer overturns our decision with respect to any Service, we will provide coverage or payment for that Service as directed.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure for your claim before you may request external review unless we have failed to comply with federal requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all

Termination or Rescission of Membership

Termination Generally

Subject to our right to 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, practice, or omission that constitutes fraud, or make a 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.
- The Group's membership with a bona fide association is terminated; or
- 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.

Rescission of Membership

We may rescind the membership of the Subscriber and any enrolled dependents after it becomes effective (completely cancel your membership so that no coverage ever existed) if you or your enrolled dependents did any of the following before your membership became effective:

- In the first two years of becoming a Member, we determine you made a misrepresentation of material fact in connection with your application for membership.
- After two years, membership will be rescinded only in the event of a misrepresentation of material fact in your written application. Fraud means the willful misrepresentation of a material fact. A copy of the application will be given to you.

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 Member Services Department at (404) 261-2590 (local) or 1-888-865-5813 (long distance). A Member Services 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 Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance). A Member Services representative will be glad to help you.

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 Member Services Department, seven days a week, from 8 a.m. to 8 p.m., at (404) 233-3700 (local) or 1-800-232-4404 (long distance) or 1-800-255-0056 (TTY).

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 Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) 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 currently are undergoing an active course of 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 condition or terminal illness or if you are inpatient. The Services may be covered for up to 60 days, from the date of the provider contract termination date 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 Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) 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 Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) 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, its services, its 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 Member Services 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.

Claims review authority

We are responsible for determining whether you are entitled to benefits under this EOC and we have the discretionary authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If coverage under this EOC is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" with respect to review of claims under 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 Member Services Department at (404) 261-2590 (local) 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.

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

1. You are a Member on the date the covered Service is rendered;

2. You have not met the maximum benefit amount for the Service, if any. A maximum benefit usually applies per Member per Year.

3. The Services are to be provided by a Plan Provider (unless the Service is to be provided by a non-Plan Provider subject to an approved referral as described in the Referral section, above) in accordance with the terms and conditions of this EOC including but not limited to the requirements, if any for Prior Authorization:

4. The Services are Medically Necessary; and,

5. You receive the Services from a Plan Provider and in accordance with our notice of Prior Authorization, if required, unless Services are qualified Emergency Services as described previously.

If you receive Services and we determined the Services are not t covered Services, then Health Plan will not pay for such Services. In order to be covered Services, your care must be both (1) a benefit as described in this Section, and (2) Medically Necessary. You will be responsible for all charges for the Services. Charges you pay for non-covered Services will not count toward the satisfaction of the Annual Deductible, if any, 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 Eligible Charges 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 any 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.

Prior Authorization for Services

Certain covered Services require Prior Authorization in advance of your appointment or admission in order to be covered. Please call our Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance) to find out the Services that require Prior Authorization.

If you received Services and Prior Authorization was required but not obtained or the Services were later determined not to be Medically Necessary, Health Plan will not cover the Services. You will be responsible for all charges for the Services.

Before giving approval, we consider if the Service is a covered benefit under your plan, and Medically Necessary.

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

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 Provider in departments other than those listed under “Primary care visits” above.

Preventive Visits and Services

We cover a variety of preventive care Services, which are Services that do one or more of the following:

- Protect against disease, such as in the use of immunizations
- Promote health, such as counseling on tobacco use
- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer

The “Schedule of Benefits” section explains Copayments, Coinsurance and deductible requirement for some preventive care Services, but it does not otherwise explain coverage. These preventive care Services are subject to all coverage requirements described in other parts of this “Benefits” section and all provisions in the “General Exclusions, Limitations, and Reimbursement of Health Plan” section. For example, we cover a preventive care Service that is an outpatient laboratory Service only if it is covered under the “Office Services” section, subject to the “General Exclusions, Limitations, Reimbursement of Health Plan and Coordination of Benefits” section.

We cover at no charge (not subject to the Annual Deductible) the preventive care Services listed on our "Preventive Care Services Covered with No Copayments, Coinsurance, or Annual Deductible requirements" list. This list is subject to change at any time and is available from our Members Services Department or on our website at www.kp.org.

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.

Notes:

- If your attending Plan Physician determines, after conferring with you, that you will be discharged less than 48 hours after delivery (or 96 hours if delivery is by cesarean section), your physician will order a follow-up visit for you and your newborn to take place within 48 hours after discharge and may order a second visit if appropriate. Please see the Notice Regarding Your Health Insurance Coverage at the end of this EOC for further information.
- 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, or your newborn is not admitted to the normal newborn nursery, your newborn's hospital stay is a separate inpatient admission. All applicable inpatient facility charges and hospital charges will apply to your newborn's stay.

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 Member Services Department.)
- Outpatient surgery (including professional charges);
- Outpatient facility/hospital charges (including professional charges);
- Chemotherapy (and all other visits to infusion centers); and
- Radiation Therapy.

Physical, Occupational, and Speech Therapy, and Cardiac Rehabilitation

Physical, Occupational, and Speech Therapy, and Cardiac Rehabilitation require Prior Authorization before you receive such Services, as described under "Authorization for Services" at the beginning of this section. If Prior Authorization is not obtained for the Services you receive you will be responsible for all charges for such Services.

Your plan may also include day or visit limits for physical, occupational and speech therapy. 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 or hospice care.

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, except for traumatic brain injury, 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 are 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 for:
  - Educational placement or other educational purposes;
  - Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation;
  - Tongue thrust in the absence of swallowing problems; and
  - Voice therapy for occupation or performing arts.

Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease when all of the following conditions are met:

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

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

EMERGENCY SERVICES

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency room. You do not need Prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or non-Plan Providers anywhere in the world, as long as the Services are covered under “Emergency Services” in the “How to Obtain Services” section. Emergency Services that you receive from Plan Providers are subject to the “General Exclusions, Limitations, and Reimbursement of Health Plan”.

“Emergency Services” are described under the “How to Obtain Services” section of this EOC.

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 when 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 the "How to Obtain Services" 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.

After-Hours Urgent Care

We cover Services for an unexpected illness or injury that does not meet the criteria described under "Emergency Services" at our designated **Kaiser Permanente After-Hours Care Centers**. Our Health Line is available 24 hours a day, 7 days a week (404) 365-0966 (local) or 1-800-611-1811 (long distance) to provide medical advice or assist with making an appointment. Services must be obtained at **Kaiser Permanente After-Hours Care Centers** or at the Affiliated Community After-Hours Urgent Care Centers designated by Health Plan.

"After-Hours Urgent Care" is described under the "How to Obtain Services" section of this EOC.

INPATIENT SERVICES

Hospital Inpatient Care

All Plan Hospital admissions, except for Emergency Services as described under the "How to Obtain Services" section require Prior Authorization 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.

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;
- 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 require Prior Authorization as described under "Authorization for Services" at the beginning of this section.

We cover the following mental health Services:

- 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 psychiatric hospitalization in a Plan Hospital. These Services include Services of Plan Providers and other mental health professionals when performed, prescribed or directed by the Plan Providers or Plan Physicians, 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

- Mental Health Services that in the judgment of the Medical Group Physician are not responsive to counseling or medication management.
- 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.

Chemical Dependency Services

Outpatient and Inpatient Detoxification Services

All inpatient Chemical Dependency Services described in this section require Prior Authorization 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.

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 (FDA). Immunizations that are in general use and were developed after March 1 of the year immediately preceding the year this EOC became effective or was last renewed are payable at half of the Eligible Charges;
- Intravenous (IV): drugs, fluids, additives, nutrients and the supplies and equipment required for their administration;
- Allergy test and treatment materials when administered in an outpatient setting.

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 Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) 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 require Prior Authorization 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.

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

Home Health Care

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

We cover the following home health care services only when ordered by a Plan Physician, approved by the Quality Resource Management Program and when you are confined to your home.

- Intermittent skilled nursing care visits provided by or under the supervision of a registered nurse. A visit may consist of up to 4 hours of skilled nursing Services;
- Home health aide Services, provided in conjunction with skilled nursing care;
- Medical social services; and
- Medical supplies.

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

- Pharmacy Services;
- Durable Medical Equipment (DME);
- Physical, Occupational, and Speech Therapy; and
- Prosthetics and Orthotics.

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

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 administered by a person who normally lives in the home or who is a member of the family.
- Care that the Medical Quality Resource Management Program 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.

Hospice Care

We cover hospice care which includes care 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 we determine 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 Prior Authorization has been obtained and the Services that are provided by a licensed hospice agency approved in writing by us:

- Physician and nursing care;
- Therapies, such as physical, occupational, or respiratory, 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;
- 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.

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

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.

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 Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance).
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- Extraction of bony impacted wisdom teeth
- 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, except as described above are not covered;
- 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.

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 (DME) as described in this section require Prior Authorization as described under "Authorization for Services" at the beginning of this section.

Within our Service Area, we cover DME 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. DME also includes infant apnea monitors.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. DME 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 DME, 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.

DME Care exclusions

- 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 resulting from misuse are not covered.
- More than one piece of DME serving essentially the same function is not covered, except for replacements other than those resulting from misuse or loss.
- Spare or alternate use equipment is not covered.

Prosthetics and Orthotics

All Prosthetics and Orthotics as described in this section require Prior Authorization 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).
- 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.

Infertility Services

All Infertility Services as described in this section require Prior Authorization 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 fasting blood glucose, fasting insulin, 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

- We exclude all services and drugs related to the diagnosis and treatment of infertility, unless specifically noted to the contrary in the “Additional Benefits Purchased by Your Group” section of this EOC. Services to diagnose the non-reproductive medical cause of infertility are covered.
- 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.

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

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.

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 require Prior Authorization 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”.

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 require Prior Authorization 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).

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.

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 contact 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).
- Corrective lenses and eyeglasses are not covered, except where specifically noted to the contrary in this EOC.
- Visual training
- Low vision aids

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.

Inpatient Treatment

All patient treatment 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 the “Benefits” section.

We cover the following Services:

- Hospital Services;
- Medical treatment for withdrawal symptoms;
- Counseling (both individual and group); and
- Inpatient specialized treatment programs.

Chemical Dependency Services Exclusions

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

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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.

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Outpatient Prescription Drugs

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

Preferred 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 prescription drug. It is a drug which is designated as a Generic Preferred Drug by us and is listed by us as a drug preferred or favored to be dispensed. Generic drugs not appearing on the preferred list are called Non-Preferred Drugs.

Brand Preferred Drug is a prescription drug that has been patented and is only produced by one manufacturer and is listed by us as a drug preferred or favored to be dispensed. Brand drugs not appearing on the preferred list are called Non-Preferred Drugs.

Non-Preferred Drug is a prescription drug that is not listed by us as a drug preferred or favored to be dispensed.

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 and supplies for which a prescription is required by law. Certain diabetic supplies do not require a prescription. While you may obtain a first fill of your prescription at either a Kaiser Permanente Medical Center Pharmacy or at a Health Plan designated community pharmacy, all refills of your prescription must be obtained at a Kaiser Permanente Medical Center Pharmacy or through our Automated Refill Center. To locate a Kaiser Permanente Medical Center Pharmacy, you should refer to your Physician Directory or call our Member Services Department Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance). You may also visit us online at www.kp.org.

- Each prescription refill is provided on the same basis as the original prescription. Copayments are applied up to the lesser of 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. 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.

Unless otherwise specified by your Plan Physician or dentist, Generic Drugs may be used to fill a prescription. If you request a Brand Name Drug that has a generic equivalent at a Kaiser Permanente Medical Center pharmacy or at a community pharmacy designated by Health Plan, you pay the full cost difference between the Generic Drug and the Brand Name Drug, in addition to the applicable Copayment, Coinsurance and deductible shown in "Schedule of Benefits" section at the end of this EOC.

Unless otherwise specified by your Select Provider or dentist, Generic Drugs may be used to fill a prescription. If Brand Name Drugs are used to fill a prescription and a Generic Drug is available, you will pay the cost difference between the Generic Drug and the Brand Name Drug in addition to the applicable Copayment, Coinsurance and at a Kaiser Permanente Medical Center pharmacy, you pay the cost difference between the Generic Prescription Drug and the Brand Name Drug in addition to the applicable Copayment, Coinsurance and deductible shown in the "Schedule of Benefits" section at the end of this EOC.

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.
- 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
- Outpatient prescription drugs and injectables for the treatment of involuntary infertility.

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 drug requires authorization, please call our Member Services Department, Monday through Friday from 7 a.m. to 7 p.m. at (404) 261-2590 (local) or 1-888-865-5813 (long distance). You may also visit us online at www.kp.org.

Outpatient Prescription Drugs Home Delivery Service

We cover prescription drug home delivery services from our Kaiser Permanente Automated Refill Center. 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 home delivery two 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; or

2. Call our pharmacy home delivery line at (770) 4342008. Home delivery prescriptions must be paid for in advance by credit card.

You may order up to a 90-day supply. You are responsible for paying the applicable Copayments, Coinsurance and deductibles. There is no shipping charge and no additional fees for home deliveryprescriptions.

Please allow five to seven 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 home delivery service. Examples of drugs that cannot be mailed include those listed below. Items available through our home delivery pharmacy are subject to change at any time without notice.

- 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 rider.
- Drugs in classes determined excluded by our Pharmacy and Therapeutics Committee.
- Drugs for smoking cessation are not covered.
- Immunizing agents, biological sera, blood or blood plasma are not covered.
- Drugs for the treatment of alopecia is not covered.
- Experimental or investigational drugs are not covered.
- Anti-wrinkle agents are not covered.
- Retinoids (e.g. Retin-A, Differin, Tazorac)for individuals 36 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.
- Drugs determined by the Pharmacy and Therapeutics Committee to warrant restriction to certain age groups.
- Drugs and injectables for the purpose of weight loss or the treatment of obesity are not covered.
- Drugs and injectables for the treatment of sexual dysfunction disorders are not covered.

GA12HMO-RX 11/09 (12RXTKPPN)

Infertility Treatment Services

We cover Services related to the treatment of involuntary infertility once a condition of infertility has been diagnosed. This includes Services for further diagnosis to attempt to determine the cause of infertility. These Services are covered only when received from Plan Providers.

Artificial Insemination

We cover Services for artificial insemination, including laboratory and radiology tests and procedures.

Administered Drugs

We cover infertility drugs 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 covered home visits.

Infertility Treatment Services Exclusions

- Services to reverse voluntary, surgically induced infertility are not covered.
- Outpatient prescription drugs for the treatment of involuntary infertility are covered only if your Group has purchased that additional benefit. Refer to the “Additional Benefits Purchased by Your Group” section for more information.
- Ovum transplants are not covered.
- Gamete intrafallopian transfer (GIFT) is not covered.
- Services related to the collection, procurement, washing, preparation or storage of sperm or eggs, including donor fees or cryopreservation are not covered.
- Zygote intrafallopian transfer (ZIFT) is not covered.

GA09HMOAB-INFTX 08/08 (9HIFXVDN)

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.

GA07HMOAB-CHIRO 08/06

Schedule of Benefits

For CITIGROUP, INC.

This section summarizes:

- Your Cost Sharing (if any)
- Dependent age limit
- Benefit limits such as day limits, visit limits and benefit maximums.

Dollar limits, day and visit limits, are based on a calendar year.

This section does not describe all the details of your benefits. To learn more about your benefits, please refer to the appropriate sections of the EOC.

You are responsible for payment of:

- Copayments
- Coinsurance
- Annual Deductible and any other deductibles applicable to this plan
- Any amounts in excess of the Eligible Charges or Benefit Maximums

as shown in this "Schedule of Benefits" section.

Dependent Age limit

The Dependent age limit as described in the "Premium, Eligibility, Enrollment and Effective Date" section of the EOC is 26. A dependent child will continue to be eligible until the end of the year in which the dependent child 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. Likewise, your deductibles and Coinsurance Out-of-Pocket Maximum under this EOC are on a calendar year basis. Any amounts that you paid in the same calendar year, under a prior EOC from the same employer Group, toward the Annual Deductible or any other deductible and Coinsurance Out-of-Pocket Maximum shall carry-forward and count toward satisfaction of the deductibles and Coinsurance Out-of-Pocket Maximum shown in this EOC.

The annual dollar, day and visit limits, deductibles and Out-of-Pocket Maximums are based on calendar year. Your Cost Sharing for Services is due at the time of your visit. For items ordered in advance, you pay your Cost Sharing 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 Cost Sharing.

Your Coinsurance is based on the Eligible Charges for covered Services. The Eligible Charges may be less than the amount actually billed by the provider. You are responsible for payment of any amounts in excess of the Eligible Charges for a covered Service from a non-Plan Provider. Refer to the definition of Eligible Charge shown in the "Definitions" section at the beginning of this EOC.

All covered Services are subject to the Annual Deductibles and Maximum Benefit While Covered unless otherwise noted below and in this EOC. Copayments, penalties and charges in excess of Eligible Charges do not count toward satisfaction of the Annual Deductibles or the Out-of-Pocket Maximums.

Individual and Family Annual Deductibles do not count toward satisfaction of the Out-of-Pocket Maximums. Refer to the definitions of Copayment / Coinsurance Out-of-Pocket Maximum shown in the "Definitions" section at the beginning of this EOC.

Amounts you pay for the following Services do not count toward the Coinsurance Out-of-Pocket Maximum: Services for which you pay a Copayment; and optional services such as outpatient prescription drugs, private duty nursing, non-surgical dental treatment, preventive dental care, infertility treatment (including administered infertility drugs), optical hardware, chiropractic services, acupuncture services and hearing aids. Not all Services listed here may be covered under your specific plan. Refer to the remainder of this Schedule of Benefits, and this EOC, for additional information.

Schedule of Benefits

Maximum Benefit While Covered (Some specific benefits may have limitations)	Unlimited
Annual Deductible (Some specific benefits may have a deductible)	Single: $500 Family: $1,000
Coinsurance (unless otherwise specified in this EOC)	Plan Pays 90% after Annual Deductible
Coinsurance Out-of-Pocket Maximum (Applies to specific benefits)	Single: $3,000 Family: $6,000

Covered Services

OFFICE SERVICES	
Primary care visits (including laboratory Services and X-rays)	Plan Pays 90% after Annual Deductible
Specialty care visits (including laboratory Services and X-rays)	Plan Pays 90% after Annual Deductible
High tech radiology Services (including CT, PET, MRI, myelograms, and nuclear medicine scans)	Plan Pays 90% after Annual Deductible
Allergy treatment serum	Plan Pays 90% after Annual Deductible
Injection visits	Plan Pays 90% after Annual Deductible
Preventive Visits and Services	
Well-child care visits (up to age 24 months) NOTE: Cost Sharing will apply if non-preventive Services are provided during a scheduled preventive visit	Plan Pays 100% (Annual Deductible does not apply)
Annual physical exams for children age 2 and above and adults Limited to one exam every 12 months NOTE: Cost Sharing will apply if non-preventive Services are provided during a scheduled preventive visit	Plan Pays 100% for Primary Care visit Plan Pays 100% for Specialty Care visit (Annual Deductible does not apply)
Annual well-woman exams Limited to one exam every 12 months NOTE: Cost Sharing will apply if non-preventive Services are provided during a scheduled preventive visit	Plan Pays 100% for Primary Care visit Plan Pays 100% for Specialty Care visit (Annual Deductible does not apply)
Preventive care screening services and procedures (including pap smears, mammograms and prostate specific antigen (PSA) tests)	Plan Pays 100% (Annual Deductible does not apply)
Maternity Care	
Routine prenatal visits and delivery (obstetrician, nurse midwife, OB nurse practitioner) and first postpartum visit	Plan Pays 90% after Annual Deductible
All other visits during pregnancy, (including nutritionists,genetics counselors and perinatologists)	Plan Pays 90% after Annual Deductible
Maternity inpatient Services	Plan Pays 90% after Annual Deductible
Physician/Professional charges	Plan Pays 90% after Annual Deductible
OUTPATIENT SERVICES (When performed in an outpatient facility setting)	
High tech radiology Services (including CT, PET, MRI, myelograms, and nuclear medicine scans)	Plan Pays 90% after Annual Deductible

Covered Services

Outpatient surgery (including professional charges)	Plan Pays 90% after Annual Deductible
Outpatient facility/hospital charges (including professional charges, laboratory Services and X-rays)	Plan Pays 90% after Annual Deductible
Chemotherapy and other visits to infusion centers	Plan Pays 90% after Annual Deductible
Radiation therapy	Plan Pays 90% after Annual Deductible
Physical, Occupational, and Speech Therapy, and Cardiac Rehabilitation	
Physical therapy visits	Plan Pays 90% after Annual Deductible Up to 20 visits per Year
Occupational therapy visits	Plan Pays 90% after Annual Deductible Up to 20 visits per Year.
Speech therapy visits	Plan Pays 90% after Annual Deductible Up to 20 visits per Year.
Cardiac rehabilitation, 36 visits per Year	Plan Pays 90% after Annual Deductible
Dialysis Care	
Dialysis	Plan Pays 90% after Annual Deductible
EMERGENCY SERVICES	
Emergency department visits NOTE: Non-emergency use of the emergency department is not covered	$100 Copayment (If you are admitted to the hospital as an inpatient, the charge will be waived)
Ambulance Services	Plan Pays 90% after Annual Deductible per trip
After Hours Urgent Care	
After hours urgent care Services	Plan Pays 90% after Annual Deductible
INPATIENT SERVICES	
Hospital Inpatient Care	
Inpatient hospital (including medical detoxification)	Plan Pays 90% after Annual Deductible
Physician/Professional charges	Plan Pays 90% after Annual Deductible
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES	
Outpatient Mental Health	
Outpatient individual therapy	Plan Pays 90% after Annual Deductible
Outpatient group therapy	Plan Pays 90% after Annual Deductible
Outpatient Mental Health visits for the purpose of monitoring drug therapy	Plan Pays 90% after Annual Deductible
Partial Hospitalization	Plan Pays 90% after Annual Deductible
Inpatient Mental Health	
Inpatient mental health facility	Plan Pays 90% after Annual Deductible
Physician/Professional charges	Plan Pays 90% after Annual Deductible
Outpatient Chemical Dependency Treatment	
Outpatient therapy (performed in a physician's office)	Plan Pays 90% after Annual Deductible.
Outpatient therapy (performed in an outpatient facility/hospital)	Plan Pays 90% after Annual Deductible
Outpatient group therapy	Plan Pays 90% after Annual Deductible
Inpatient Chemical Dependency Treatment	
Inpatient treatment	Plan Pays 90% after Annual Deductible

Physician/Professional charges	Plan Pays 90% after Annual Deductible
PHARMACY SERVICES	
Drugs and Supplies	
Administered drugs for treatment of infertility	Plan Pays 50%
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.	
Covered drugs	
Generic Preferred Drugs	$10 Copayment at Kaiser Permanente Medical Center Pharmacies and $20 Copayment at designated community pharmacies.
Brand Name Preferred Drugs	$20 Copayment at Kaiser Permanente Medical Center Pharmacies and $30 Copayment at designated community pharmacies.
Non-Preferred Drugs	$40 Copayment at Kaiser Permanente Medical Center Pharmacies and $50 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
Drugs for treatment of infertility	Plan Pays 50%
Home Delivery Drugs	When you order a 90-day supply through our Kaiser Permanente Outpatient Prescription Home Delivery Service, you will pay two times the applicable Copayments, you would pay for a 30-day supply. Any applicable deductible and coinsurance will continue to apply to total refill ordered. There is no shipping charge and no additional fees for home delivery prescriptions.
OTHER SERVICES	
Skilled Nursing Facility Care	
Room and board, skilled nursing Services (including Physician/Professional charges) Up to 100 days per Year	Plan Pays 90% after Annual Deductible
Home Health Care	
Covered Services	Plan Pays 90% after Annual Deductible
Hospice Care	
For hospice care instead of traditional Services	Plan Pays 90% after Annual Deductible
Dental Care	
Dental Services and appliances for accidental bodily injury to sound and natural teeth	Plan Pays 50% $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 90% after Annual Deductible

Prosthetics and Orthotics	
Covered devices	Plan Pays 90% after Annual Deductible
Infertility Services	
Diagnosis Services	Refer to the Office Services, Outpatient Services and Inpatient Services sections of this Schedule of Benefits for payment information.
Treatment Services (including related imaging, lab tests, procedures and professional Services)	Plan Pays 50%
Vision Services	
Screening for eye disease	Plan Pays 90% after Annual Deductible
Eye exams for corrective lenses (Does not include fitting for cosmetic contact lenses)	Plan Pays 90% after Annual Deductible
Chiropractic Services	
Up to 20 visits per Year	Plan Pays 90% after Annual Deductible