Pick the right plan for you

We offer several types of plans for individuals and families. All feature quality care—the main difference is how you pay for it. Many preventive care services are no charge—no matter which plan you choose.

CLASSIC PLANS

- Doctor's office visits available for a copayment
- Predictable out-of-pocket expenses

Our Classic plans offer unlimited physician visits for just a copay. Many other services, such as Emergency Room visits, after-hours visits, and generic drugs, are also available for just a copay.

Our Classic plans:

– Classic 1500

– Classic 2500

– Classic 3500

– Classic 5000

ESSENTIAL PLANS

- Copays for many outpatient services
- Many services 100% covered after deductible

Our Essential plans offer copays for primary care office visits, most outpatient services, and generic prescription drugs. Many services, such as specialist office visits and inpatient hospital care, are covered in full after you meet your deductible.

Our Essential plans:

– Essential 1500

– Essential 3000

– Essential 5000

– Essential 7500

ADVANTAGE PLANS

- Primary care doctor's office visits available for a copay
- First two specialist's office visits for a copay before deductible

Our Advantage plans offer moderate copays and lower premiums. Many services, such as Emergency Room visits, after-hours visits, and generic drugs, are also available for a copay before you meet your deductible.

Our Advantage plans:

– Advantage 2500

– Advantage 3500

– Advantage 5000

– Advantage 7500

HSA PLANS

- Covered services available at no charge after deductible
- Option to pay medical expenses with tax-deductible dollars[1]

Our HSA-qualified deductible plans offer a tax-free way to build savings to pay for qualified medical expenses when paired with an optional HSA (health savings account).

Our HSA-qualified plans:

– HSA 5000 Single

– HSA 10000 Family

[1] Tax references relate to federal income tax only. Please consult a financial or tax adviser for tax savings information.

QUESTIONS? Call **1-800-494-5314** Visit **buykp.org/apply** Contact your agent or broker today!

How deductible plans work

Deductible plans generally offer lower monthly premiums in exchange for paying more out of your own pocket for services covered by your health plan. With these plans, you pay full charge for most covered services until your expenses meet an annual deductible. Then, for covered services, you pay a copayment or coinsurance.

Deductibles

Under a deductible plan, many covered services are subject to the deductible—the set amount for which you pay full charge in a calendar year. This means you'll pay full charge for certain medical services until you reach your annual deductible.

No deductible for select services

In our traditional deductible plans, some services are available for a copay before you meet your deductible. For example, generic drugs and primary care, specialty care, and urgent care visits are not subject to the deductible. And to encourage you to receive preventive care, many of these services are available for no charge before you meet your deductible.

Out-of-pocket maximum

Your out-of pocket maximum puts a cap on how much you'll spend on most covered services each calendar year. This helps protect you financially if you have a serious illness or injury.

For example, if you are enrolled in the Advantage 3500 plan, you would pay full charge for most services covered by your plan until you spend $3,500 out of pocket to meet your individual deductible. (Copays do not contribute toward the deductible.) To reach your $5,000 out-of-pocket maximum, you would need to spend an additional $5,000 in coinsurance after you meet your deductible.

In our traditional deductible plans, the deductible does not contribute to the out-of-pocket maximum. In our HSA-qualified deductible plans, the deductible does contribute to the out-of-pocket maximum.

Using a deductible plan

Let's say you injure your ankle and visit your primary care physician, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

On the Classic 1500 plan, you have to pay $1,500 out of pocket before you are eligible to pay a coinsurance for most covered services.

Under this plan, however, some services are not subject to the deductible. That means you can pay a copayment for these services before you meet your deductible.

In this example, even if you have not met your deductible, you would pay a $35 copayment (or copay) for the doctor's office visit and a $15 copay for the preferred generic drug. The X-ray would be no charge. Amounts you pay for copayments do not contribute to your annual deductible.

However, if you had had a more serious injury that required an ambulance or outpatient surgery, you would have paid full charge for those services because they are subject to the deductible. Whatever amount you paid out of pocket for those services would contribute toward your annual deductible.

Visit the treatment fee tool at **kp.org/treatmentestimates** to estimate your out-of-pocket costs for upcoming services.

The HSA difference

Some of our deductible plans are HSA-qualified deductible plans. These plans can be paired with an optional health savings account, or HSA. HSA-qualified plans work similarly to traditional deductible plans with just a few differences:

- If you're eligible, you can open an HSA with an HSA-qualified plan.
- Money you deposit into your HSA is deductible on your federal income tax form.
- You can use funds from your HSA to pay for qualified medical expenses.
- In our traditional deductible plans, the deductible does not contribute to the out-of-pocket maximum.

  In our HSA-qualified deductible plans, the deductible does contribute to the out-of-pocket maximum.

Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser. To learn more about health savings accounts, visit www.irs.gov/publications/p969/ar02.html or call 1-800-829-1040.

Benefit highlights

	CLASSIC PLANS			
	CLASSIC 1500	CLASSIC 2500	CLASSIC 3500	CLASSIC 5000
FEATURES	**Copays and the deductible do not contribute to the out-of-pocket maximum. Coinsurance does contribute to the out-of-pocket maximum.**			
Annual deductible (individual/family)	$1,500/$3,000	$2,500/$5,000	$3,500/$7,000	$5,000/$10,000
Annual out-of-pocket maximum (after deductible) (individual/family)	$1,500/$3,000	$2,500/$5,000	$3,500/$7,000	$5,000/$10,000
BENEFITS	**Services not subject to deductible unless otherwise indicated**			
PREVENTIVE CARE				
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.				
OUTPATIENT SERVICES (per visit or procedure)				
Primary care office visit (nonpreventive)	$35 copay			
Specialist office visit (nonpreventive)	$60 copay			
Most X-rays and lab tests	No charge			
MRI, CT, and PET	20% coinsurance (after deductible)			
Outpatient surgery	20% coinsurance (after deductible)			
Mental health	20% coinsurance (after deductible)			
INPATIENT HOSPITAL CARE				
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	20% coinsurance (after deductible)			
MATERNITY				
Delivery and postpartum	Not covered			
EMERGENCY AND URGENT CARE				
Emergency Room visit (waived if admitted)	$250 copay			
Urgent care (after-hours visit)	$75 copay			
Ambulance service	20% coinsurance (after deductible)			
PRESCRIPTION DRUGS[1]	(when filled at Kaiser Permanente pharmacies)			
Pharmacy deductible (individual/family)	$500/$1,000 (brand drugs only)			
Preventive generic drugs[1]	$5 copay			
Preferred generic drugs	$15 copay			
Brand drugs	$45 copay (after pharmacy deductible)			
Specialty drugs ($5,000 out-of-pocket maximum)	50% coinsurance (after pharmacy deductible)			

This plan summary is intended to highlight only some of the principal provisions of our plans. Please refer to the *Evidence of Coverage*, available upon acceptance, for more details of your plan or for specific limitations and exclusions. Certain underwriting guidelines apply. Applicants are subject to medical review.

The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and the rate you pay under your plan, or ask you to select a new plan.

[1] Prescribed contraceptives are no charge.

QUESTIONS? Call **1-800-494-5314** Visit **buykp.org/apply** Contact your agent or broker today!

Benefit highlights

	ESSENTIAL PLANS			
	ESSENTIAL 1500	ESSENTIAL 3000	ESSENTIAL 5000	ESSENTIAL 7500
FEATURES	**Copays and the deductible do not contribute to the out-of-pocket maximum. Coinsurance does contribute to the out-of-pocket maximum.**			
Annual deductible (individual/family)	$1,500/$3,000	$3,000/$6,000	$5,000/$10,000	$7,500/$15,000
Annual out-of-pocket maximum (after deductible) (individual/family)	$0			
BENEFITS	**Services not subject to deductible unless otherwise indicated**			
PREVENTIVE CARE				
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.				
OUTPATIENT SERVICES (per visit or procedure)				
Primary care office visit (nonpreventive)	$75 copay			
Specialist office visit (nonpreventive)	No charge (after deductible)			
Most X-rays and lab tests	No charge			
MRI, CT, and PET	$250 copay			
Outpatient surgery	$500 copay			
Mental health	$120 copay			
INPATIENT HOSPITAL CARE				
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	No charge (after deductible)			
MATERNITY				
Delivery and postpartum	Not covered			
EMERGENCY AND URGENT CARE				
Emergency Room visit (waived if admitted)	$500 copay			
Urgent care (after-hours visit)	$150 copay			
Ambulance service	No charge (after deductible)			
PRESCRIPTION DRUGS[1]	(when filled at Kaiser Permanente pharmacies)			
Pharmacy deductible (individual/family)	$1,000/$2,000 (brand drugs only)			
Preventive generic drugs[1]	$5 copay			
Preferred generic drugs	$15 copay			
Brand drugs	50% coinsurance (after pharmacy deductible)			
Specialty drugs ($5,000 out-of-pocket maximum)	50% coinsurance (after pharmacy deductible)			

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[1] Prescribed contraceptives are no charge.

Contact your agent or broker today!

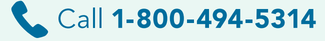
Benefit highlights

	ADVANTAGE PLANS			
	ADVANTAGE 2500	ADVANTAGE 3500	ADVANTAGE 5000	ADVANTAGE 7500
FEATURES	**Copays and the deductible do not contribute to the out-of-pocket maximum. Coinsurance does contribute to the out-of-pocket maximum.**			
Annual deductible (individual/family)	$2,500/$5,000	$3,500/$7,000	$5,000/$10,000	$7,500/$15,000
Annual out-of-pocket maximum (after deductible) (individual/family)	$5,000/$10,000			
BENEFITS	**Services not subject to deductible unless otherwise indicated**			
PREVENTIVE CARE				
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.				
OUTPATIENT SERVICES (per visit or procedure)				
Primary care office visit (nonpreventive)	$45 copay			
Specialist office visit (nonpreventive)	First 2 office visits: $75 copay / 3+ visits: 30% coinsurance (after deductible)			
Most X-rays and lab tests	No charge			
MRI, CT, and PET	30% coinsurance (after deductible)			
Outpatient surgery	30% coinsurance (after deductible)			
Mental health	30% coinsurance (after deductible)			
INPATIENT HOSPITAL CARE				
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	30% coinsurance (after deductible)			
MATERNITY				
Delivery and postpartum	Not covered			
EMERGENCY AND URGENT CARE				
Emergency Room visit (waived if admitted)	$500 copay			
Urgent care (after-hours visit)	$100 copay			
Ambulance service	30% coinsurance (after deductible)			
PRESCRIPTION DRUGS[1]	(when filled at Kaiser Permanente pharmacies)			
Pharmacy deductible (individual/family)	$1,000/$2,000 (brand drugs only)			
Preventive generic drugs[1]	$5 copay			
Preferred generic drugs	$15 copay			
Brand drugs	$45 copay (after pharmacy deductible)			
Specialty drugs ($5,000 out-of-pocket maximum)	50% coinsurance (after pharmacy deductible)			

This plan summary is intended to highlight only some of the principal provisions of our plans. Please refer to the *Evidence of Coverage*, available upon acceptance, for more details of your plan or for specific limitations and exclusions. Certain underwriting guidelines apply. Applicants are subject to medical review.

The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and the rate you pay under your plan, or ask you to select a new plan.

[1] Prescribed contraceptives are no charge.



QUESTIONS? Call **1-800-494-5314** Visit **buykp.org/apply** Contact your agent or broker today!

How HSA-qualified deductible plans work

An HSA-qualified plan is a deductible plan that is eligible to be paired with an optional health savings account, or HSA. If you sign up for an HSA-qualified plan and open an HSA, you can pay for qualified medical expenses with tax-deductible dollars.[1]

An HSA-qualified plan works much like a traditional deductible plan. You pay full charges for certain covered services out of pocket until you reach your deductible. Then you are eligible to receive those services for no charge. The main difference is that you can save money with HSA-qualified plans. This is because you can pay for qualified medical expenses—even those not covered by your health plan—with tax-deductible dollars. However, qualified expenses not covered by your health plan will not contribute to your deductible or out-of-pocket maximum.

All you have to do is:

- Sign up for an HSA-qualified health plan.
- If you are eligible, open a health savings account.
- Contribute tax-deductible dollars to this account.[2]
- Use those tax-free funds to pay for qualified health care expenses.

What you don't use rolls over to the next year and continues earning interest.[3]

Advantages of opening an HSA

- **Portability.** The money belongs to you, so if you change health plans, you can take your HSA with you.
- **Rollover of unused funds.** There is no "use it or lose it" restriction each year. What you don't use stays in your account until you are ready to use it.[3]
- **Control.** You decide when to put the money in and when to take it out.
- **Retirement savings.** The money in your account can be invested through the institution where you open it. And after age 65, you can use the funds, taxed at your ordinary income rate, for any reason without penalties.
- **Flexibility.** You can use the money in your HSA to pay for qualified medical expenses, even those your deductible plan does not cover.

An HSA offers triple tax advantages

- Tax-deductible contributions to your account
- Tax-free investment earnings
- Tax-free withdrawals when funds are used for qualified medical expenses

[1] Tax references relate to federal income tax only. The tax treatment of health savings account contributions and distributions under state income tax laws differs from the federal tax treatment. Consult with your financial or tax adviser for more information.

[2] For 2013, the federally established maximum contribution for an eligible individual with self-only coverage is $3,250. The federally established maximum contribution for an eligible individual with family coverage is $6,450. This annual maximum is indexed annually for inflation. Tax savings refer to federal income tax only. For more information, please consult your financial or tax adviser.

[3] Earnings vary depending on the type of investment plan you opt for and/or the HSA provider you choose. Amount earned is based on the investment plan and market value, and in some instances, the account may actually lose money.

Using a health savings account

What are qualified medical expenses?

You can use an HSA to pay for deductibles, copays, coinsurance, and many supplies and services not covered by your health plan. Generally, these are expenses that would qualify for the medical and dental expense deduction on your income tax.

Here are just a few examples of HSA-qualified expenses:

- Eyeglasses and laser eye surgery
- Dental care
- Acupuncture
- Chiropractic services
- Hearing aids

For a complete list, see *Publication 502, Medical and Dental Expenses* at www.irs.gov.

Who's eligible for an HSA?

To be eligible for an HSA, you need to meet the following requirements:

- You can't be enrolled in Medicare.
- You can't be eligible to be claimed as a dependent on someone else's tax return.
- You can't have additional health coverage that is not a qualified deductible plan (with certain exceptions).
- You can't have received benefits from the Department of Veterans Affairs in the past three months.

You may set up your HSA through any financial institution that offers these accounts.[1]

Using an HSA-qualified deductible plan

Let's say you injure your ankle and visit your primary care physician, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

Under our HSA-qualified plans, all covered services other than preventive care are subject to your deductible. On the HSA 5000 Single plan, you would pay the first $5,000 of your medical and pharmacy expenses out of pocket. Then you would pay no charge for covered services for the rest of the year.

In this example, you would pay full charge for the doctor's office visit, the X-ray, and the medication. All your out-of-pocket costs for covered services would be applied to your $5,000 deductible.

And, if you opened an HSA, you would be able to pay for these services with tax-free dollars. (Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser. For more information on health savings accounts, please visit www.irs.gov/publications/p969/ar02.html.)

[1] Kaiser Permanente does not provide or administer financial products, including HSAs, and does not offer financial, tax, or investment advice. Members are responsible for their own investment decisions. If a member uses his or her HSA debit card to pay for something other than a qualified medical expense, the expenditure is subject to tax and, for individuals who are not disabled or over 65, a 20 percent tax penalty. Please note that when an HSA provider pays disbursements, it does not monitor whether they are for qualified medical expenses. It is the member's responsibility to determine whether expenses qualify for tax-free reimbursement from his or her HSA.

Benefit highlights

	HSA PLANS	
	HSA 5000 SINGLE	**HSA 10000 FAMILY**
FEATURES	**The deductible contributes to the out-of pocket maximum.**	
Annual deductible	$5,000	$10,000
Annual out-of-pocket maximum (after deductible)	$0	
BENEFITS	**Services not subject to deductible unless otherwise indicated**	
PREVENTIVE CARE		
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge.		
OUTPATIENT SERVICES (per visit or procedure)		
Primary care office visit (nonpreventive)	No charge (after deductible)	
Specialist office visit (nonpreventive)	No charge (after deductible)	
Most X-rays and lab tests	No charge (after deductible)	
MRI, CT, and PET	No charge (after deductible)	
Outpatient surgery	No charge (after deductible)	
Mental health	No charge (after deductible)	
INPATIENT HOSPITAL CARE		
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	No charge (after deductible)	
MATERNITY		
Delivery and postpartum	Not covered	
EMERGENCY AND URGENT CARE		
Emergency Department visit (waived if admitted)	No charge (after deductible)	
Urgent care (after-hours visit)	No charge (after deductible)	
Ambulance service	No charge (after deductible)	
PRESCRIPTION DRUGS[1]	(when filled at Kaiser Permanente pharmacies)	
Pharmacy deductible	N/A	
Preventive generic drugs[1]	No charge (after deductible)	
Preferred generic drugs	No charge (after deductible)	
Brand drugs	No charge (after deductible)	
Specialty drugs ($5,000 out-of-pocket maximum)	No charge (after deductible)	

This plan summary is intended to highlight only some of the principal provisions of our plans. Please refer to the *Evidence of Coverage*, available upon acceptance, for more details of your plan or for specific limitations and exclusions. Certain underwriting guidelines apply. Applicants are subject to medical review.

The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and the rate you pay under your plan, or ask you to select a new plan.

[1] Prescribed contraceptives are no charge.

QUESTIONS?

Contact your agent or broker today!

Frequently asked questions

Here are some of the most common questions people have about our plans. If you have questions about a specific type of plan or a particular benefit, please see the "Benefit Highlights." Or you may call us at **1-800-494-5314**. We'll be happy to answer any questions. If you are working with an agent or a broker, please contact him or her for assistance.

How does the Affordable Care Act affect the plan I'm applying for?

The benefits that you select may change on January 1, 2014. At that time, in order to meet the new benefit standards under the Affordable Care Act, we may change the benefits and the rate you pay under your plan, or ask you to select a new plan. In any case, we value your membership and will provide options for you to continue your coverage without a break.

I've heard about a *Summary of Benefits and Coverage* document. What is it? And how do I get one?

As part of the Affordable Care Act, you now have access to *Summary of Benefits and Coverage (SBC)* documents to help you make an informed health plan choice. These documents summarize important information about your health coverage options, so you can easily compare Kaiser Permanente benefits and coverage with those of other carriers. *SBCs* for all our plans are available at healthcare.gov.

What is the difference between routine physical exams, primary care office visits, and specialist office visits?

- A routine physical exam is an annual office visit to your primary care physician during which your doctor will perform preventive screenings as indicated by your age, gender, and general health.
- A primary care office visit is a visit (other than a routine physical exam) to your primary care physician, usually a general practitioner in internal medicine, family practice, or pediatrics.
- A specialist office visit is a visit to a doctor other than a primary care physician, such as a dermatologist or orthopedist.

Is a physical exam required to apply?

No. All you have to do is complete the medical questionnaire included in your application.

Can I apply to enroll my children?

Yes. You may apply to enroll your children on any plan as a part of your family plan. You may also enroll a child as a single subscriber in our Child-Only Plan during the open enrollment period of January 1, 2013, through January 31, 2013, or if you experience a qualifying event.

To what age can my children be covered on my plan?

Children can be covered as dependents until they turn 26.

I have children away at school. Are they covered outside the service area?

Dependents attending school outside our service area are covered only for urgent and emergency out-of-area benefits, just as when you are traveling.

Frequently asked questions *(continued)*

Are preventive care services covered?

Yes, and many are available for no charge. You don't have to meet a deductible first for many preventive care services.

Are prescription medications covered?

All our plans offer prescription coverage. You can fill prescriptions at any of our Kaiser Permanente medical facilities. You can also order most prescription refills online at **kp.org/rxrefill** or by phone and have your prescriptions mailed directly to your home at no extra charge. If you must fill a prescription at a nonaffiliated pharmacy because of an emergency or urgent care event outside our pharmacy hours, you must pay full charge and file a paper claim for reimbursement. However, you may fill your first prescription at any Walgreens or Rite Aid for a higher copayment. All subsequent refills must be filled at a Kaiser Permanente pharmacy.

What are preventive generic drugs?

We offer preventive generic drugs at a discount to help you control the cost of your prescription drugs and maintain your health for ongoing conditions, such as asthma, high cholesterol, and high blood pressure. Additionally, many of these medications are also available through our home delivery service in which your mail-order benefit can help you save even more when you order a 90-day supply.

Do lower premiums mean fewer benefits?

No. All our plans include coverage for the big things, such as hospitalization, as well as routine care, such as doctor's office visits and preventive care. You don't have to wait for an emergency before you can use your health coverage.

Important details and notices

ABOUT YOUR COVERAGE

Before you review the specific plan information, check to make sure you live within our service area. You're eligible to apply for Kaiser Permanente for Individuals and Families (KPIF) coverage if you live in one of the following counties: 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, or Walton.

Check for service availability in Clarke, Madison, Oconee, and Oglethorpe counties in 2012.

Once you are enrolled, you can enjoy the benefits of KPIF until you choose to leave the plan, regardless of health. However, please note that coverage can end for failure to pay premiums when due or for misrepresentation of medical or other important information on your application.

When you turn 65 or become eligible for Medicare, you have the option to apply for our Senior Advantage plan. If you are already eligible for Medicare as your primary coverage, you are not eligible for KPIF, but you can apply for Senior Advantage. You can ask about our coverage for Medicare-eligible members by calling toll free **1-800-232-4404**.

If you have any questions or would like more information, just call our Call Center at **1-800-494-5314** or check out the KPIF website at **buykp.org**.

DRUG FORMULARY

Kaiser Permanente uses a drug formulary for our HMO and HSA Option plans. Our drug formulary is a continually updated list of medications that are determined to be safe and effective. Use of formulary drugs enables us to provide quality care at a reasonable cost.

If you request a nonformulary drug, you will be responsible for the full cost of that drug, unless there is a clear medical reason to use it rather than the similar formulary drug. In specific cases, such as allergy to the formulary alternative, your physician may request an exception for coverage of a nonformulary drug at your regular pharmacy copay. Certain prescriptions require expert review before they can be dispensed.

If you have any questions about the formulary, call **(404) 261-2590**.

PREAUTHORIZATION

When you need to obtain preauthorization for covered services or have a question about whether a service requires preauthorization, please contact the Kaiser Permanente Utilization Management Department at **(404) 364-7320** or **1-800-221-2412** (TTY/TDD **1-800-255-0056**).

At Kaiser Permanente, the Utilization Management Program works with participating providers to plan, organize, and deliver quality health care services by ensuring these services are medically appropriate, medically necessary, and provided in a cost-effective manner. Some services require preauthorization by the Utilization Management Program.

Examples include, but are not limited to:

- Elective inpatient admissions
- Outpatient surgery
- Specialized services such as home health, medical supplies/equipment, and hospice care
- Skilled nursing and acute rehabilitation facilities
- Certain behavioral health services and/or chemical dependency treatment

Failure to obtain preauthorization may result in penalties against your benefit payment, or we may deny all or part of your claim. In the event any service is denied because it does not meet criteria, you may request an appeal.

Kaiser Permanente does not use financial incentives to encourage barriers to care and service. Decisions involving utilization management are based only on appropriateness of care and service, and existence of coverage under the

(continues)

Important details and notices *(continued)*

member's benefit plan. Kaiser Permanente does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, and does not use financial incentives that encourage decisions that result in under utilization.

Kaiser Permanente is prohibited from making decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

EXCLUSIONS

As with all health plans, there are some exclusions. The following services are excluded from all coverage. (Please note that this is a summary—for a complete list, refer to the *Evidence of Coverage*.)

- Services that an employer or any government agency is responsible to provide, including workers' compensation
- Custodial care or care in an intermediate care facility
- Services provided or arranged by criminal justice institutions or mental health institutions for members in the custody of law enforcement officers if you are confined in the institution, except for emergency services
- Cosmetic services (including drugs and injectables)
- Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient
- Dental services, devices, and appliances other than those specified (including most hospital services for dental care)
- Physical examinations required for obtaining or maintaining employment or participation in employee programs, or insurance or government licensing
- Experimental or investigational services
- Refractive surgery or corrective lenses, eyeglasses, and hearing aids
- Orthoptics (eye exercises)
- Services and drugs related to the treatment of obesity
- Routine foot care services
- Examinations for the prescription of hearing aids
- All services and drugs related to sexual reassignment surgery
- Long-term physical, speech, and occupational therapy and rehabilitation
- Cognitive rehabilitation programs
- Vocational rehabilitation
- Services that are primarily educational in nature
- Cost of semen and eggs
- Services for conception by artificial means, including infertility drugs
- Reversal of voluntary infertility
- Nonhuman and artificial organs and their implantation
- Court-ordered services
- Mental health services for chronic conditions and mental retardation after diagnosis
- Testing for ability, aptitude, intelligence, or interest
- Corrective shoes and orthotic foot supports and inserts
- More than one device for the same part of the body or same function
- Replacement of lost devices
- Electronic monitors of bodily functions (except infant apnea monitors and blood glucose monitors)
- Devices to perform medical testing of body fluids, excretions, or substances
- Devices not medical in nature
- Convenience, comfort, or luxury items
- Reconstructive surgery following removal of breast implants that were inserted for cosmetic reasons
- Drugs for the treatment of sexual dysfunction disorders
- Most disposable supplies
- Transportation and lodging

Important details and notices *(continued)*

WHO PROVIDES THE COVERAGE

HMO and HSA Option plans are provided by Kaiser Foundation Health Plan, Inc.

THIS IS ONLY A SUMMARY

This is a summary description and is not intended to replace your *Individual Agreement* or *Evidence of Coverage*, which contain the complete provisions of this coverage. If you have questions or need additional information, please call **(404) 261-2590**.

FOR MORE INFORMATION

Have a question that's not answered in this information kit? Just contact our Call Center at **1-800-494-5314** or check out our website at **buykp.org/apply**.

Privacy practices

HIPAA NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Important Information about the protection of oral, written, and electronic information.

NOTICE OF PRIVACY PRACTICES KAISER PERMANENTE, GEORGIA REGION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

In this notice we use the terms *we*, *us*, and *our* to describe Kaiser Permanente, Georgia Region. For more details, please refer to section IV of this notice.

I. WHAT IS "PROTECTED HEALTH INFORMATION"?

Your protected health information (PHI) is individually identifiable health information, including demographic information; information about your past, present, or future physical or mental health or condition; health care services you receive; and past, present, or future payment for your health care. Demographic information means information such as your name, address, and date of birth.

PHI may be in oral, written, or electronic form. Examples of PHI include your medical record, claims record, enrollment or disenrollment information, and communications between you and your health care practitioner about your care.

If you are a Kaiser Foundation Health Plan member and also an employee of any Kaiser Permanente company, PHI does not include the health information in your employment records.

In the course of providing and administering health care, we collect various types of health information from various sources, such as you, other members (for example, your spouse or parents), and other health care professionals. The types of information we collect and maintain about our members include, among other things, medical and hospital records, such as general medical, mental health, and substance abuse patient records, laboratory results, X-ray results, pharmacy records, and appointment records.

Kaiser Permanente collects other health plan information using a variety of techniques. Examples include:

- Collecting information from you through surveys, applications, related forms, and other written requests and communications;
- Collecting information from your employer, benefits plan sponsor, or association regarding group coverage that you may have through group applications, census data, and other written requests and communications;
- Collecting information from visitors to our website such as online forms, site visit data, and other online communications; and
- Collecting information from consumer or medical reporting agencies or other sources such as insurance support organizations and credit bureaus.

II. ABOUT OUR RESPONSIBILITY TO PROTECT YOUR PHI

By law, we must

1. protect the privacy of your PHI;
2. tell you about your rights and our legal duties with respect to your PHI; and
3. tell you about our privacy practices and follow our notice currently in effect.

(continues)

Important details and notices *(continued)*

We take these responsibilities seriously and have put in place administrative safeguards (such as security awareness training and policies and procedures), technical safeguards (such as encryption and passwords), and physical safeguards (such as locked areas and requiring badges) to protect your PHI. As in the past, we will continue to take appropriate steps to safeguard the privacy of your oral, written, and electronic PHI.

III. YOUR RIGHTS REGARDING YOUR PHI

This section tells you about your rights regarding your PHI, for example, your medical and billing records. It also describes how you can exercise these rights.

Your right to see and receive copies of your PHI

In general, you have a right to see and receive copies of your PHI in designated record sets such as your medical record or billing records. If you would like to see or receive a copy of such a record, please write to us at Kaiser Foundation Health Plan of Georgia, Release of Information, 4000 DeKalb Technology Parkway, Suite 200, Atlanta, GA 30340.

In limited situations, we may deny some or all of your request to see or receive a copy of your records, but if we do, we will tell you why in writing and explain your right, if any, to have our denial reviewed.

Your right to choose how we send PHI to you

You may ask us to send your PHI to you at a different address (for example, your work address) or by different means (for example, fax instead of regular mail). If the cost of meeting your request involves more than a reasonable additional amount, we are permitted to charge you our costs that exceed that amount.

Your right to correct or update your PHI

If you believe there is a mistake in your PHI or that important information is missing, you may request that we correct, delete, or add to the record. Please write to us and tell us what you are asking for and why we should make the correction, deletion, or addition. Your request should be sent as described above in the section titled **"Your right to see and receive copies of your PHI."** If we approve your request, we will make the correction or addition to your PHI. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement.

Your right to an accounting of disclosures of PHI

You may ask us for a list of our disclosures of your PHI. If you would like a list of disclosures, please write to us as described above in the section titled **"Your right to see and receive copies of your PHI."** The list we give you will include disclosures made in the last six years, unless you request a shorter time period, or if less than six years have passed since April 14, 2003. For example, if you requested a list of disclosures on April 14, 2005, the list would cover only two years.

You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional accountings less than 12 months later, we may charge a fee.

Except as may otherwise be required under state law, an accounting does not include certain disclosures; for example, disclosures to carry out treatment, payment, and health care operations; disclosures that occurred prior to April 14, 2003; disclosures for which Kaiser Permanente, Georgia Region, had a signed authorization; disclosures of your PHI to you; disclosures for notifications for disaster relief purposes; or disclosures to persons involved in your care and persons acting on your behalf.

Your right to request limits on uses and disclosures of your PHI

You may request that we limit our uses and disclosures of your PHI for treatment, payment, and health care operations purposes. We will review and consider your request. You may write to us at Kaiser Foundation Health Plan of Georgia, Release of Information, 4000 DeKalb Technology Parkway, Suite 200, Atlanta, GA 30340, for consideration of your request.

Your right to receive a paper copy of this notice

You also have a right to receive a paper copy of this notice upon request.

Important details and notices *(continued)*

IV. KAISER PERMANENTE COMPANIES SUBJECT TO THIS NOTICE

This notice applies to Kaiser Permanente, Georgia Region, which includes:

- The Southeast Permanente Medical Group, Inc. (TSPMG);
- Kaiser Foundation Health Plan of Georgia, Inc., including its health plan and provider operations;
- Kaiser Foundation Hospitals (KFH), as described below; and
- Kaiser Foundation Health Plan, Inc. (KFHP, Inc.), as described below.

Our health care delivery sites include Kaiser Permanente medical centers, our member call advice and appointment centers, and our member website.

To provide you with the health care you expect when treating you, paying for your care, and conducting our operations, such as quality assurance, accreditation, licensing, and compliance, these Kaiser Permanente companies share your PHI with each other.

Our personnel may have access to your PHI as employees, physicians, volunteers, persons working with us in other capacities, or professional staff members and others authorized to enter information into a medical record of a Kaiser Permanente Medical Center. Our region may also share your PHI with KFH and KFHP, Inc., in connection with shared services and other national Kaiser Permanente activities for treatment, payment, or health care operations purposes. For example, if you are being considered for a transplant, we will share your PHI with our Kaiser Permanente National Transplant Network.

V. HOW WE MAY USE AND DISCLOSE YOUR PHI

Your confidentiality is important to us. Our physicians and employees are required to maintain the confidentiality of the PHI of our members/patients, and we have policies and procedures and other safeguards to help protect your PHI from improper use and disclosure. Sometimes we are allowed by law to use and disclose certain PHI without your written permission. We briefly describe these uses and disclosures below and give you some examples.

How much PHI is used or disclosed without your written permission will vary depending, for example, on the intended purpose of the use of disclosure. Sometimes we may need to use or disclose only a limited amount of PHI, such as to send you an appointment reminder or to confirm that you are a health plan member. At other times we may need to use or disclose more PHI, such as when we are providing medical treatment.

- **Treatment**: This is the most important use and disclosure of your PHI. For example, our physicians, nurses, and other health care personnel, including trainees, involved in your care use and disclose your PHI to diagnose your condition and evaluate your health care needs. Our personnel will use and disclose your PHI in order to provide and coordinate the care and services you need, for example, prescriptions, X-rays, and lab work. If you need care from health care providers who are not part of Kaiser Permanente, such as community resources to assist with your health care needs at home, we may disclose your PHI to them.
- **Treatment alternatives and health-related benefits and services**: In some instances, the law permits us to contact you: 1) to describe our network or describe the extent to which we offer and pay for various products and services; 2) for your treatment; 3) for case management and care coordination; or 4) to direct or recommend available treatment options, therapies, health care providers, or care settings. For example, we may tell you about a new drug or procedure or about educational or health management activities.
- **Payment**: Your PHI may be needed to determine our responsibility to pay for, or to permit us to bill and collect payment for, treatment and health-related services that you receive. For example, we may have an obligation to pay for health care you receive from an outside

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Important details and notices *(continued)*

provider. When you or the provider sends us the bill for health care services, we use and disclose your PHI to determine how much, if any, of the bill we are responsible for paying.

- **Health care operations**: We may use and disclose your PHI for certain health care operations, such as quality assessment and improvement; training and evaluation of health care professionals; licensing; accreditation; activities relating to the creation, renewal, or replacement of health insurance or health benefits; conducting medical review; legal services; auditing functions, including fraud and abuse detection and compliance programs; customer services; and determining premiums and other costs of providing health care. We may also disclose your PHI for certain health care operations of other health plans and health care providers.
- **Business associates**: We may contract with business associates to perform certain functions or activities on our behalf, such as payment and health care operations. These business associates must agree to safeguard your PHI.
- **Appointment reminders**: Your PHI allows us to contact you about appointments for treatment or other health care you may need.
- **Specific types of PHI**: There are stricter requirements for use and disclosure of some types of PHI, for example, drug and alcohol abuse patient information, mental health records, and HIV/AIDS information. However, there are still circumstances in which these types of information may be used or disclosed without your authorization. If you become a patient in our chemical dependency program, we will give you a separate written notice, as required by law, about your privacy rights for your chemical dependency program PHI.
- **Communications with family and others when you are present**: Sometimes a family member or other person involved in your care will be present when we are discussing your PHI with you. If you object, please tell us and we won't discuss your PHI or we will ask the person to leave.
- **Communications with family and others when you are not present**: There may be times when it is necessary to disclose your PHI to a family member or other person involved in your care because there is an emergency, you are not present, or you lack the decision making capacity to agree or object. In those instances, we will use our professional judgment to determine if it's in your best interest to disclose your PHI. If so, we will limit the disclosure to the PHI that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.
- **Disclosure in case of disaster relief**: We may disclose your name, city of residence, age, gender, and general condition to a public or private disaster relief organization to assist disaster relief efforts, unless you object at the time.
- **Disclosures to parents as personal representatives of minors**: In most cases, we may disclose your minor child's PHI to you. In some situations, however, we are permitted or even required by law to deny your access to your minor child's PHI. Examples of when we must deny such access include situations involving your daughter's pregnancy, the prevention of her pregnancy, childbirth, and abortion records where a court waives parental notification of abortion. In addition, the law denies access to your child's PHI if your child is married or otherwise emancipated.
- **Research**: Kaiser Permanente engages in extensive and important research. Some of our research may involve medical procedures and some is limited to collection and analysis of health data. Research of all kinds may involve the use or disclosure of your PHI. Your PHI can generally be used or disclosed for research

Important details and notices *(continued)*

without your permission if an Institutional Review Board (IRB) approves such use or disclosure. An IRB is a committee that is responsible, under federal law, for reviewing and approving human subjects research to protect the safety of the participants and the confidentiality of PHI.

- **Organ donation**: Except as limited by applicable law, we may use or disclose PHI to organ-procurement organizations to assist with organ, eye, or other tissue donations.
- **Public health activities**: Public health activities cover many functions performed or authorized by government agencies to promote and protect the public's health and may require us to disclose your PHI.
  - For example, we may disclose your PHI as part of our obligation to report to public health authorities certain diseases, injuries, conditions, and vital events such as births or abortions. Sometimes we may disclose your PHI to someone you may have exposed to a communicable disease or who may otherwise be at risk of getting or spreading the disease.
  - The Food and Drug Administration (FDA) is responsible for tracking and monitoring certain medical products, such as pacemakers and hip replacements, to identify product problems and failures and injuries they may have caused. If you have received one of these products, we may use and disclose your PHI to the FDA or other authorized persons or organizations, such as the maker of the product.
  - We may use and disclose your PHI as necessary to comply with federal and state laws that govern workplace safety.
- **Health oversight**: As health care providers and health plans, we are subject to oversight conducted by federal and state agencies. These agencies may conduct audits of our operations and activities, and in that process they may review your PHI.
- **Disclosures to your employer or your employee organization**: If you are enrolled in Kaiser Foundation Health Plan of Georgia through your employer or employee organization, we may share certain PHI with them without your authorization but only when allowed by law. For example, we may disclose your PHI for a workers' compensation claim or to determine whether you are enrolled in the plan or whether premiums have been paid on your behalf. For other purposes, such as for inquiries by your employer or employee organization on your behalf, we will obtain your authorization when necessary.
- **Workers' compensation**: In order to comply with workers' compensation laws, we may use and disclose your PHI. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers' compensation benefits.
- **Military activity and national security**: We may sometimes use or disclose the PHI of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your PHI to authorized federal officials as necessary for national security and intelligence activities or for protection of the president and other government officials and dignitaries.
- **Marketing**: Kaiser Permanente may use and, in some instances, disclose your PHI to contact you about benefits, services, or supplies that we can offer you in addition to your Kaiser Permanente coverage.
- **Fundraising**: We may use or disclose PHI to contact you to raise funds for our organization.
- **Required by law**: In some circumstances, federal or state law requires that we disclose your PHI to others. For example, the secretary of the Department of Health and Human Services may review our compliance efforts, which may include seeing your PHI.

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Important details and notices *(continued)*

- **Lawsuits and other legal disputes**: We may use and disclose PHI in responding to a court or administrative order, a subpoena, or a discovery request. We may also use and disclose PHI to the extent permitted by law without your authorization, for example, to defend a lawsuit or arbitration.

- **Law enforcement**: We may disclose PHI to authorized officials for law enforcement purposes, for example, to respond to a search warrant, report a crime on our premises, investigate fraud, or help identify or locate someone.

- **Serious threat to health or safety**: We may use and disclose your PHI if we believe it is necessary to avoid a serious threat to your health or safety or to someone else's.

- **Abuse or neglect**: By law, we may disclose PHI to the appropriate authority to report suspected child abuse or neglect or to identify suspected victims of abuse, neglect, or domestic violence.

- **Coroners and funeral directors**: We may disclose PHI to a coroner or medical examiner to permit identification of a body, determine cause of death, or for other official duties. We may also disclose PHI to funeral directors.

- **Inmates**: Under the federal law that requires us to give you this notice, inmates do not have the same rights to control their PHI as other individuals. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your PHI to the correctional institution or the law enforcement official for certain purposes, for example, to protect your health or safety or someone else's.

VI. ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

Except for those uses and disclosures described above, we will not use or disclose your PHI without your written authorization. When your authorization is required and you authorize us to use or disclose your PHI for some purpose, you may revoke that authorization by notifying us in writing at any time. Please note that the revocation will not apply to any authorized use or disclosure of your PHI that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health care coverage from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

VII. HOW TO CONTACT US ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or want to lodge a complaint about our privacy practices, please let us know by calling or writing to Member Services Department, Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, Georgia 30305-1736. **If you are enrolled in a plan other than Senior Advantage,** you may call Member Services at **(404) 261-2590**. Its hours of operation are Monday through Friday, 7 a.m. to 7 p.m.

If you are enrolled in Senior Advantage, you may call the Senior Advantage Member Services Department at **(404) 233-3700** or toll free at **1-800-232-4404** (TTY: **1-800-255-0056**). Its hours of operation are seven days a week, 8 a.m. to 8 p.m. You also may notify the secretary of the Department of Health and Human Services (HHS). We will not take retaliatory action against you if you file a complaint about our privacy practices.

VIII. CHANGES TO THIS NOTICE

We may change this notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. If we make an important change to our privacy practices, we will promptly change this notice and provide a new notice on our member website at **kp.org** and in our member publications, *Partners in Health*. Except for changes required by law, we will not implement an important change to our privacy practices before we revise this notice.

Important details and notices *(continued)*

IX. EFFECTIVE DATE OF THIS NOTICE

This notice is effective on March 19, 2010.

Consumer Choice Option

As part of Georgia state law, another option is available to you through Kaiser Permanente for Individuals and Families (KPIF) called the *Consumer Choice Option*. This option can be added to any of our KPIF plans.

- With Consumer Choice Option, you can nominate and use providers not normally available through Kaiser Permanente.
- You still receive benefits comparable to those you would receive when using in-plan or select providers.
- This option costs 17.5% more than what is quoted in the rates for this year.

If you would like more information on the Consumer Choice Option—including an election form, information on how to nominate a provider, and rate information—please call Member Services at **(404) 261-2590**.

If you think you would be interested in enrolling in the Consumer Choice Option, please wait until after you receive and review the materials to return your medical questionnaire. The medical questionnaire and Consumer Choice Option election form must be returned to Kaiser Permanente at the same time.

QUESTIONS? Call **1-800-494-5314** Visit **buykp.org/apply** Contact your agent or broker today!