



# guide to
## YOUR BENEFITS AND SERVICES

kaiserpermanente.org

Your 2025
Group Plan
Evidence of Coverage

ACCREDITED NCQA HEALTH PLAN ACCREDITED

★★★★☆

KAISER PERMANENTE®
Georgia Region

BOOK 25ENL1HM

# IMPORTANT

## Notices Regarding Your Health Plan 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 treatment of physical complications at all stages of the mastectomy, including lymphedemas.

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.

### Non-Discrimination

Kaiser Foundation Health Plan of Georgia, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with Us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If You need these services, call **1-888-865-5813** (TTY: **711**)

If You believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance by mail at: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: 1-888-865-5813.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## HELP IN YOUR LANGUAGE

**ATTENTION:** If You speak English, language assistance services, free of charge, are available to You. Call **1-888-865-5813** (TTY: **711**).

**አማርኛ (Amharic) ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-865-5813** (TTY: **711**).

**العربية (Arabic) ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-865-5813** (TTY: **711**).

**Carolinian (Kapasal Falawasch):** ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye **1-888-865-5813** (TTY: **711**).

**Chamorro (Chamoru)**: Para un ma ayuda gi finu Chamoru, å'gang: **1-888-865-5813** (TTY: **711**).

**中文 (Chinese) 注意：**如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-888-865-5813**（TTY：**711**）。

**فارسی (Farsi) توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-865-5813** (TTY: **711**)تماس بگیرید.

**Français (French) ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-865-5813** (TTY: **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-865-5813** (TTY: **711**).

**ગુજરાતી (Gujarati) સૂચના:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-865-5813** (TTY: **711**).

**Kreyòl Ayisyen (Haitian Creole) ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-865-5813** (TTY: **711**).

**हिन्दी (Hindi) ध्यान दें:** यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-865-5813** (TTY: **711**) पर कॉल करें।

**日本語 (Japanese) 注意事項：**日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-865-5813**（TTY: **711**）まで、お電話にてご連絡ください。

**한국어 (Korean) 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-865-5813** (TTY: **711**) 번으로 전화해 주십시오.

**Naabeehó (Navajo) Díí baa akó nínízin:** Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-888-865-5813** (TTY: **711**).

**Pennsylvania Dutch (Deitsch):** Fer Hilf griege in Deitsch, ruf **1-888-865-5813** (TTY: **711**) uff.

**Português (Portuguese) ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-865-5813** (TTY: **711**).

**Русский (Russian) ВНИМАНИЕ:** если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-865-5813** (TTY: **711**).

**Español (Spanish) ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-865-5813** (TTY: **711**).

**Samoan (Gagana Samoa):** Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni **1-888-865-5813** (TTY: **711**).

**Tagalog (Tagalog) PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-888-865-5813** (TTY: **711**).

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-865-5813** (TTY: **711**).

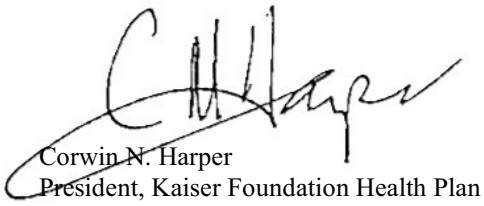
## *Welcome to Kaiser Permanente!*

Thank you for selecting 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 your HMO plan by reviewing this Evidence of Coverage (EOC). The EOC gives you important information about your health plan and about accessing care at Kaiser Permanente. If you need help understanding it, just let us know. To help you get started, you will also receive your I.D. card(s) and other communications separately.

If you have questions about your health plan 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.
We look forward to being your partner in health.

Sincerely,



Corwin N. Harper
President, Kaiser Foundation Health Plan of Georgia, Inc

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(GA25ENL1HMO 09/24)

# SECTION 1 - Introduction

## About Your Health Plan from Kaiser Permanente's HMO Plan

You have selected the Kaiser Permanente HMO Plan.

Kaiser Foundation Health Plan of Georgia, Inc. is a nonprofit health care plan licensed as a health maintenance organization in Georgia. We provide or arrange medical care for Members on a pre-paid basis.

Kaiser Foundation Health Plan of Georgia, Inc. is sometimes referred to as "Health Plan," "We," "Our," or "Us".

In this EOC, You and Your covered Dependents are sometimes referred to as "You" or "Your". Further, some capitalized terms may have a special meaning in this EOC, please see the "SECTION 9 - Definitions" section for terms You should know.

*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 approval by the Georgia Department of Insurance. 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 have consented to the changes. This consent will also apply to You and to Your enrolled Dependents.

We provide health care benefits to Members using Our Medical Group Physicians, Affiliated Community Physicians, and other Plan Providers located in Our Service Area, which is described in Our "SECTION 9 - Definitions" section. For Services to be covered, they must be Medically Necessary to prevent, diagnose, or treat a medical condition, and must be provided, prescribed or directed by a Plan Provider.

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
- Receiving Care in Another Kaiser Region.

When You receive care, 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 are limits to the total amount of Copayments, Coinsurance, and deductibles You must pay each Year for certain covered Services covered under this EOC. Refer to the "Schedule of Benefits" section for more information.

This EOC, along with any applications for membership in this Plan and any amendments and/or riders found in "Section 10 – Additional Benefits and Schedule of Benefits," constitute the entire contract ("Agreement") between You and Health Plan. No agent or employee of Health Plan may change any provisions or benefits or declare any part of this contract invalid.

## Premium, Eligibility, Enrollment, and Effective Date

### *Premium*

By payment of Premium, You accept this EOC for Yourself and all Your enrolled Dependents, if any.

You are entitled to health care coverage under Your Health Plan 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

Your Group is solely responsible for setting all eligibility requirements for coverage, making enrollment decisions and communicating enrollment information to Us. Any questions, concerns, or disputes regarding such requirements and decisions should be directed to Your Group.

### *Dependents*

If You are a Subscriber, and if Your Group and Plan allows for the 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, children placed with You for adoption, or children placed with You for foster care, if Your Group provides coverage for foster children) who are under Dependent limiting age shown in the "Schedule of Benefits" section.

- Children for whom You or Your Spouse is the court-appointed guardian (or was when the child reached age 18).
- Dependents who are older than the Dependent limiting age, 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; and
  - You give Us proof of incapacity and dependency annually if We request it.

## 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.

### *Surviving or Divorced Spouse*

In the event of the death of the Subscriber, You are entitled to a Special Enrollment Period. A divorced spouse of a Subscriber loses eligibility at the end of the month the divorce is final (See the "Special Enrollment" section below).

### *Dependent Child*

A child loses eligibility either at the end of the month or end of the Plan Year in on the date which the child reaches the age of 26. Your Group will make the determination as to Your child's eligibility. See the "Schedule of Benefits" section for more information.

**Please note** that if You have other health coverage in addition to the coverage under this EOC, in most instances You will not be eligible to establish or contribute to an HSA unless both coverages qualify as High Deductible Health Plans. Consult with Your financial or tax advisor for tax advice or more information about Your eligibility for an HSA.

## 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 the "Special Enrollments" section below).

### *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.

### *Special Enrollments*

**1. 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 placed with You for foster care (if provided by Your Group);
- 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.

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, and any additional premium paid 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, and any additional premium paid within 31 days of that date for membership to continue.
- For children placed with You for foster care, the legal placement for foster care, but the child must be enrolled, and any additional premium paid 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 so long as any additional Premiums due is paid.

**NOTE**: **In order to be covered, all Services for any newborn child must be provided or arranged by a Plan Physician and/or Plan Facility.**

**2. Special Enrollment Due to Loss of Other Coverage**

- 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.

**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.

**3. 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 date 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.

**4. Other Special Enrollment**

You may enroll as a Subscriber (along with any eligible Dependents) if You or Your Dependents were not previously enrolled and existing Subscribers may add eligible Dependents not previously enrolled if You experience any of the following qualifying events:

- You lose employment for a reason other than gross misconduct.
- Your employment hours are reduced and Your employer coverage ends.
- You are a Dependent of someone who becomes entitled to Medicare.
- You become divorced or legally separated.
- You are a Dependent of someone who dies.

You must submit an enrollment application to Us within 30 days after loss of other coverage. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

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

# SECTION 2 - How to Obtain Services

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

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

As a Member, You are selecting Kaiser Permanente as Your health care plan. 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 Services will also require Prior Authorization by Health Plan. When You receive covered 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 approved by Us in advance, **We will not pay for them except when they are Emergency Services.** 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.
- Receiving Care in Another Kaiser Region.

To receive and/or to be eligible for payment for covered Services, You must be enrolled in the Health Plan on the date on which You receive each covered Service (even if Your enrollment is terminated retroactively). Anyone who is not a Member on the date the Service is provided will be billed for any Services We provide in the amount of the applicable Eligible Charge. Requests for payment from Plan Providers for covered Services will be denied if You are not a Member on the date of which the Services are rendered. We may seek payment for any claims paid to Plan Providers for Services rendered after termination of Your enrollment.

Covered Services for Members are provided or directed by 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 services 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 other Plan Providers or 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, a specific Service, and Coinsurance for some Services. When You pay a Copayment, Annual Deductible, 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.

You may choose to receive certain covered High-Tech radiology Services or Outpatient Surgery Services at a facility operated by Health Plan such as Our medical centers or at an outpatient facility designated by Health Plan. The Outpatient surgery cost share applies in the office setting when a licensed staff member monitors Your vital signs as You regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Refer to Our Physician Directory or You may access Our website at **www.kp.org** for a list of locations where You may receive Your Services. Your Cost Sharing typically is lower when You receive covered Services at facilities operated by Health Plan.

## 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 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 for members who are under the age of 19.

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 Medical 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**.

## Referrals

If Your Kaiser Permanente personal physician determines that You require covered Services from a specialist, You will be referred to a Plan Provider. **You will need to obtain a referral from Your Kaiser Permanente personal physician prior to receiving specialty care Services from Our Medical Group providers (who practice in Kaiser Permanente medical offices)**. You do not need a referral from any Plan Provider for the specialties described in the "Self-Referral" section below.

For Services which require a referral and Prior Authorization, 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, exceed the number) 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 Providers, he or she will refer You to a non-Plan Provider. This referral must also be approved prior to Services being rendered. **You must have an approved written referral to the Plan Provider, when required, or 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 change personal physicians, You need to discuss the specialty referral with Your new personal physician to obtain a new referral.

If You receive specialty Services for which You did not obtain a referral, You will be responsible for all charges associated with those Services including but not limited to, any Cost Sharing that You may owe for such Services. Additionally, ongoing referrals for specialty Services must be made by Your current personal physician at the time of the referral.

## Self-Referral

You do not need a referral from Your Kaiser Permanente personal physician for appointments with Plan Dermatology, Behavioral Health, Optometry, Ophthalmology, Adult Primary Care, Family Practice, Obstetrics and Gynecology, or Pediatric Care 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.

The Plan Physician, however, may have to get Prior Authorization for certain non-routine 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.

# SECTION 3 - Getting the Care You Need

## Emergency Services and Urgent Care

Visit www.kp.org/travel for information on receiving Emergency and Urgent Care Services while traveling.

### *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 (where available) or go to the nearest hospital emergency department or Independent Freestanding 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 be covered under the "SECTION 7 - Benefits" section (subject to the "SECTION 8 - 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*

If You receive Post Stabilization Care in Georgia (and state or federal law does not require Us to consider the Post-Stabilization Care as Emergency Services), Prior Authorization is required. **Therefore, it is very important that You, Your provider including Your non-Plan Provider, or someone else acting on Your behalf, call Us to notify Us that You need Post Stabilization Care and to get Prior Authorization from Us before You receive the Post-Stabilization Care.**

After We are notified, We will discuss Your condition with Your non-Plan, emergency care Provider. If Your Emergency Services are provided by non-Plan Providers, We will try to arrange for Plan Providers to take over Your care as soon as Your medical condition and the circumstances allow as We determine. 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 only if We cannot arrange to have a Plan 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 that is medically required to get You to the provider. This may include transportation that is otherwise not covered.

Even if You receive Emergency Services from a Plan Provider, You must still obtain Prior Authorization from Us *before* You receive Post-Stabilization Care from such Plan Provider. We may direct that You receive covered Post-Stabilization Care at a particular Plan Hospital or other Plan Facility (such as a Skilled Nursing Facility) so that We may better coordinate Your care using Medical Group Physicians and Our electronic medical record system. **We will only pay for Post-Stabilization Care at the Plan Provider authorized by Us.**

To request Prior Authorization for Post-Stabilization Care, You, Your provider, or someone else acting on Your behalf 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 You or Your treating providers do not obtain Prior Authorization from Us for Post-Stabilization Care Services that require Prior Authorization, We will not pay any amount for those Services and You may be liable to pay for these Services, in addition to any amounts such as deductibles, co-payments or coinsurance.

When You receive Emergency Services from non-Plan Providers, Post Stabilization Care may qualify as Emergency Services pursuant to state or federal law. We will not require Prior Authorization for such Post-Stabilization Care at a non-Plan Hospital when Your attending non-Plan Provider determines that, after You receive Emergency (screening and stabilization) Services, You are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider located within a reasonable travel distance taking into account Your medical Condition.

Non-Plan Providers may provide notice and seek Your consent to provide Post-Stabilization Care Services or other covered Services. Such Services will not be covered when You do not obtain Prior Authorization as described herein. If You (or Your authorized representative) consent to the furnishing of Services by non-Plan Providers, then You will be responsible for paying for such Services in the absence of any Prior Authorization.

### *Cost Sharing for Emergency Services and Post-Stabilization Care*

Please refer to the "Schedule of Benefits" for Cost Sharing for Emergency Services.

If You are admitted to a hospital from its emergency department because Your condition is not stabilized, the Cost Sharing for Plan Providers shown under "Hospital Inpatient Care" in the "Schedule of Benefits" section of this EOC applies. If You obtain Post-Stabilization Care from a Plan Provider or from a non-Plan Provider, Your Cost Sharing would also be the Cost Sharing shown under "Hospital Inpatient Care" in the "Schedule of Benefits" section of this EOC if You obtained Prior Authorization or if Your Post Stabilization Care is considered Emergency Services. If You have agreed to pay for Your care, You will be responsible for the entire cost of Your care.. More information may also be found in the "Payment and Reimbursement" Section.

### *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 transportation described under "Ambulance Services" in the "SECTION 7 - Benefits" section or "Schedule of Benefits" section, You may have to pay the non-Plan Provider and file a claim for reimbursement unless the non-Plan Provider must refrain from billing You under applicable law or 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 Your 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** condition is one that requires prompt medical attention but is not an Emergency Medical Condition. Urgent care is described under the "SECTION 7 - Benefits" section, and includes care for an illness or injury of a less critical nature, such as the flu, stomach pain, vomiting, migraine headache, sprain, etc.

### *During Normal Business Hours*

If You think You may need Urgent Care call Our Health Line, which is available 24 hours a day, 7 days a week at (404) 365-0966 (local) or 1-800-611-1811 (long distance). Our advice 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 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 Urgent Care Centers**. Services must be obtained at **Kaiser Permanente Urgent Care Centers** or at one of the Affiliated Community Urgent Care Centers designated by Health Plan. These can be found at **www.kp.org** or in Your Physician Directory.

For information about Emergency Services or After-Hours Urgent Care refer to "Emergency Services" in the "SECTION 7 - Benefits" section.

#### Cost Sharing for Urgent Care Services

The Cost Sharing for covered Services that are Urgent Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Schedule of Benefits" section. Please refer to "Emergency Services" in the "Schedule of Benefits" section for the Cost Sharing for Urgent Care consultations and exams as well as the "Payment and Reimbursement" section.

### *Services Not Covered Under The "Emergency Services and Urgent Care" and "Post Stabilization" Sections*

Coverage for Services that are not Emergency Services, Post-Stabilization Care and Urgent Care Services as described in this "Emergency Services and Urgent Care" section will be covered as described under other sections of this EOC.

## 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.

### *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.

### *Missed Appointments*

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

### *Preventive Services*

Preventive Services are described under "Preventive Visits and Services'' in Our "SECTION 7 - 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.

## Receiving Care in Another Kaiser Foundation Health Plan Service Area

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Visiting member services shall be subject to the terms and conditions set forth in this EOC including, but not limited to, those pertaining to prior authorization and approval, and cost sharing, Deductible, Copayment, or Coinsurance, as further described

in the Visiting Member Brochure available online at **www.kp.org/travel**. Certain services are not covered as visiting member services. For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call Our Away from Home Travel Line at 951-268-3900. Information is also available online at **www.kp.org/travel**.

## Moving Outside Our Service Area

If You move to another Kaiser Permanente 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 Your new service area to find out how to apply for membership there.

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

If You move outside the Service Area You may continue coverage under this EOC if You:

- Satisfy the Group's eligibility requirements, and
- Agree to return to the Service Area to receive all of Your covered Services, with the exception of Emergency Services, from Plan Providers.

You may do so 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 Medical Record Number on it, which is useful when You call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify Your medical records and membership information. You will be sent a physical ID card, and You have access to a digital version via the Kaiser Permanente app.

You should always have the same Medical Record Number. Please let Us know if We ever inadvertently issue You more than one Medical 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).

The most important information on Your card is Your Medical 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 can be affixed to Your physical 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 Eligible 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 includes 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 Yours (or Your representative's) written authorization, except as described in Our *Notice of Privacy Practices* (see below for more information).

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* 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).

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 "SECTION 9 - 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.

# SECTION 4 - Getting Assistance, Filing Claims, and Dispute Resolution

## Getting Assistance

Our Member Services Department can answer questions You have about Your benefits, available Services, and identifying Plan Providers. For example, representatives 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 providers at one of Our Medical Centers, call or visit the administrative office at the Medical Center where You receive Your care.

For help with a question or problem involving Your coverage (for example, eligibility, enrollment, claims payment, or denial of benefits), call 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 30 calendar days.
- If Your complaint remains unresolved, You may submit Your written complaint to the State of Georgia Office of Insurance and Safety Fire Commissioner or Department of Human Services. We will be sent a copy of Your complaint. We will respond in writing to the State of Georgia Office of Insurance and Safety Fire Commissioner or Department of Human Services within 10 working days of receipt of the complaint.

## 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*

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 information that We have collected and/or 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 pre-certified 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**
**Member Services Department**
**Nine Piedmont Center**
**3495 Piedmont Road, NE**
**Atlanta, GA 30305-1736**

**Or via Fax at 404-364-4743.**

- If You want Us to consider Your pre-service claim on an urgent basis, Your request should tell Us that by calling all Our Member Services Department at 404-261-2590 (local) or 1-888-865-5813 (long distance). 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 initial 15-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 send You written confirmation within 3 days after that.

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

### *Non-Urgent Pre-Service Appeal*

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

**Or via Fax at 404-364-4743.**

- 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 in writing. 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, which 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 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**
**Member Services 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 You contact Us at least 24 hours before Your care ends, You may request that We review Your concurrent claim on an urgent basis. We will decide whether Your claim is urgent or non-urgent unless Your attending health care provider tells Us Your claim is urgent. If We determine that Your claim is not

urgent, We will treat Your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize Your life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without extending Your course of covered treatment.

- 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, which 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, which may be available to You.

**Post-Service Claims and Appeals.** Post-service claims are requests that We 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, medical records, 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 370010**
**Denver, CO 80237-9998**

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

- We will review Your claim according to Our claims adjudication policies (such as following Medicare practices to determine the liability for an amount of a claim, and if We have all the information We need We will send You a written decision within 15 business days for electronic claimsand 30 calendar days for paper claims 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. You 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**

**Or via Fax at 404-364-4743.**

- 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, which may be available to You.

**Appeals of retroactive membership termination (rescission).** We may terminate Your membership retroactively (see the "SECTION 5 - 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 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. You 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, which 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 when Our final adverse benefit determination (1) relies on medical judgment (including but not limited to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a benefit), (2) concludes that a treatment is experimental or investigational; (3) concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or substance abuse) benefits; (4) involves consideration of whether We are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130); or, (5) involves a decision related to rescission of Your coverage.

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

  **MAXIMUS Federal Services**
  **3750 Monroe Avenue, Suite 705**
  **Pittsford, NY 14534**

  Or, You may fax Your request to 1-888-866-6190 or submit Your request online at www.externalappeal.com. If You have any questions or concerns during the external review process, You may call toll free 1-888-866-6205.

- You must submit a Privacy Act Statement with Your 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 877-549-8152 or You can download a copy at *https://www.cms.gov/CCIIO/Resources/Files/Downloads/notice_of_privacy_act_rights_sept_7_2010.pdf*.

- You may submit additional information to the external reviewer by sending it to the external reviewer address or fax number 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 review 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 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.

To make a request for expedited external review You may select "expedited" if submitting the review request online, or by emailing FERP@maximus.com, asking for expedited review in Your written request for external review or calling the Federal External Review Process at 888-866-6052 ext. 3326.

- 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 individual plans), You may have a right to request review in state court.

# SECTION 5 - 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 any, if:

- Your Group fails to pay Us the appropriate Premium due; or
- You perform an act, practice, or omission that constitutes fraud, or make an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) intentionally misrepresenting enrollment eligibility information or 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 civil remedies.**

- The Group's membership with a bona fide association is terminated; or
- Termination for any of these reasons is effective after written notice. All rights to benefits cease as of the date of termination.

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 Your membership after it becomes effective (completely cancel Your membership so that no coverage ever existed) if You do either of the following:

- Perform an act, practice or omission that constitutes fraud in connection with Your membership or application for membership; or
- Make an intentional misrepresentation of material fact in connection with Your membership or application for membership.

We will send written notice at least 30 days in advance of the date of rescinding Your membership, but the rescission will completely cancel Your membership so that no coverage ever existed. You will be required to pay as a non-Member for any Services that We covered. We will refund all applicable Premiums, except that We may subtract any amounts that You owe Us including but not limited to amounts for Services that were covered.

If You receive a notice that Your membership will be rescinded, You may file a timely complaint about the termination, using the complaint procedure described in the "SECTION 4 - Getting Assistance, Filing Claims, and Dispute Resolution" section of this EOC. If the complaint is filed on time, then the termination is effective on the later of (1) 30 days after written notice; or (2) after the final decision under the Claims and Appeals Procedure affirming the rescission.

**NOTE: We may report any Member fraud to the authorities for prosecution and pursue civil remedies.**

### *Termination Due to Loss of Eligibility*

If You meet the eligibility requirements described under "Who Is Eligible" in the "SECTION 1 - Introduction" 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.

### *Continuation of Coverage*

Upon loss of eligibility under "Who is Eligible" in the "SECTION 1 - Introduction" 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.

### *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.

## 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.

If You meet one of the Medicare eligibility criteria, 65 or older, medically disabled, or diagnosed with end stage renal disease (ESRD), You may enroll in Medicare Parts A and B. Please contact Your Group's benefits administrator for details on enrolling in a Medicare or retiree or disability coverage. For additional information on Medicare eligibility, please contact Social Security toll free at 1-800-772-1213 (TTY 1-800-325-0778) Monday through Friday from 7:00 a.m. to 7:00 p.m. or visit their website at https://www.ssa.gov.

# SECTION 6 - 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 and We will rely on the information in Your application.

### *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 Plan 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 or after Your membership terminates. You will owe cost sharing amounts to Plan Providers until You satisfy any deductible and/or out-of-pocket maximum amounts.

If Our contract with any Plan Provider terminates while You are under the care of that physician or hospital, We will retain financial responsibility for covered Services You receive from that physician, in excess of any applicable Deductibles, 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 Services 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 covered Services may continue 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 provider as determined by Us.
- Covered Services related to pregnancy. Covered Services will continue 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.

### *Continuation of Care with Terminated Providers*

For any continuation of care with a terminated provider (as explained in this section) 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 covered Services to continue 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 applicable 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.

### *New Technology Assessments*

We participate in Kaiser Permanente's Interregional New Technologies Committee's evaluation of new technologies. Medical Group Physicians can provide input and make requests through Us for treatments involving new technologies and their inclusion as a Service. Decisions about implementing new technologies including but not limited to those medical and behavioral health care treatments, pharmaceuticals

and medical devices, are coordinated through Kaiser Permanente's New Technology Review Committee.

***Victims of Family Violence or Sexual Abuse***
The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence or sexual assault.

## 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).

Your participation in decisions about Your health care and Your willingness to communicate with Your Plan Provider 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.

**… 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.

**… 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.

…**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.

… **a safe, secure, clean, and accessible environment.** You have the right to obtain Services in an environment that is appropriate for the provision of medical services to You and other Members. If You are disruptive, unruly, or abusive to the extent that the behavior threatens the safety of others, Our property, or Our ability to provide Services to You or to other Members, or You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship, We may:

- Select another of Our medical offices, another Plan Provider and/or a non-Plan Provider of Our choosing, from which You will receive care;
- Monitor Your visits with Your Plan Providers and/or Your visits to Our medical offices including but not limited to restricting Your access to certain areas within Our medical offices and/or being escorted by security personnel;
- Pursue legal action; or
- Take other action as We deem appropriate.

We reserve the right to determine and complete any and all appropriate actions and the timing thereof at Our discretion.

### *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.

### *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.

# SECTION 7 - Benefits

## Introduction

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

The Services described in this "SECTION 7 - 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 (a maximum benefit usually applies per Member per Plan Year) for the Service, if any;
3. The Services are provided by a Plan Provider (unless they meet the definition of **Emergency Services** or are 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; and,
4. The Services are Medically Necessary.

If You receive Services and We determined the Services are not covered Services, then Health Plan will not pay for such Services. You will be responsible for all charges for such Services if We decided not to cover such Services subject to Your right to appeal Our adverse benefit determination. Charges You pay for non-covered Services will not count toward the satisfaction of the Annual Deductible, if any, or the Out-of-Pocket Maximum(s). In addition, if You (or Your authorized representative) consent to the provision of Services by a non-Plan Provider, then We will not pay for such Services and the amount You pay will not count toward satisfaction of the Annual Deductible, if any, or the Out-of-Pocket Maximum(s).

## What You Pay

When You access covered Services, You will be required to pay applicable Cost Sharing amounts, such as Copayments, Coinsurance, and Annual Deductibles and/or other deductibles, as described in this EOC, and as shown in the "Schedule of Benefits" section. You will also be required to pay any amount in excess of Eligible Charges and any amount for Services provided by a non-Plan Provider when You consent to their provision of Services.

These terms are described in the "SECTION 9 - Definitions" section and applicable amounts are shown in the "Schedule of Benefits" section.

We pay for covered Services only when they are furnished by Plan Providers except Emergency Services, Urgent Care outside the Service Area, and certain Post-Stabilization Care Services that qualify as Emergency Services (under applicable state or federal law), and Ancillary Services for which You have Prior Authorization. Your cost sharing for these Services will be the same as if Plan Providers provided such Services as set forth in "SECTION 10: Additional Benefits and Schedule of Benefits" of this Evidence of Coverage.

For Emergency Services only, Non-Plan Providers may provide a notice and consent form seeking Your (or Your authorized representative's) agreement that You will owe the full cost of the bill for the items and services that the non-Plan Provider furnishes. If You (or Your Authorized Representative) consent, then You will be financially responsible for payment for those items and services.

## What We Pay

After You pay the Annual Deductible or other deductible, Coinsurance, or Copayments, We will provide or pay up to the Eligible Charge for covered Services.

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 satisfaction of any requirements for Prior Authorization. See "Prior Authorization for Services" shown in this section; and
- Will not exceed Eligible Charges.

## Prior Authorization for Services

**Certain covered Services require Prior Authorization, including, but not limited to, a Referral, 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 such Services are 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 to a request for Prior Authorization, We consider if the Service is a covered benefit under Your plan, and Medical Necessary.

Except as prohibited by law, Prior Authorization is not a guarantee of payment and will not result in payment for Services that are not covered benefits and Medically Necessary or if You are not enrolled on the date that Services were provided.

## Outpatient Services

We cover the following outpatient Services only when prescribed as part of care covered under the headings in this "SECTION 7 - Benefits" section, in conjunction with other parts of this "SECTION 7 - 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). Cost Share may vary by Service location;
- Outpatient surgery (including professional Services). Cost Share may vary by Service location The Out-patient surgery Cost Share applies to surgeries performed in the office setting when nerve blocks or moderate to deep sedation is administered by a licensed personnelThe Outpatient surgery cost share applies in the office setting when a licensed staff member monitors Your vital signs as You regain sensation after receiving drugs to reduce sensation or to minimize discomfort.;
- Outpatient facility/hospital Services (including professional Services);
- Chemotherapy (and all other visits to infusion centers);
- Diabetes treatment including equipment, supplies, pharmacological agents and outpatient self-management training and education that are Medically Necessary. Self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes; and
- Radiation Therapy.

(For most current information, call Our Member Services Department.)

### Tele-medicine

Tele-medicine visits (not including telephone conversations and electronic mail messages) are considered office visits, however the applicable office visit copayment, coinsurance, and/or deductible does not apply.

## Office Services

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

1. **Primary care visits** – Services from internal medicine, family practice, pediatric practitioners; and
2. **Specialty care visits,** including consultation and second opinions with Plan Provider in departments other than those listed under "Primary care visits" above.

### Health Education

We also cover a variety of health education counseling, programs, and materials to help You take an active role in protecting and improving Your health, including programs for tobacco cessation, and the management of chronic conditions (such as diabetes and asthma).

### 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.

We cover one breast pump per birth and the coverage is subject to all coverage requirements described in other parts of this "SECTION 7 - Benefits" section and all provisions in the "SECTION 8 - General Exclusions, Limitations, Reimbursement of Health Plan, and Coordination of Benefits (COB)" section. Coverage is limited to the standard item of equipment that adequately meets Your needs.

These preventive care Services are subject to all coverage requirements described in other parts of this "SECTION 7 - Benefits" section and all provisions in the "SECTION 8 - General Exclusions, Limitations, Reimbursement of Health Plan and Coordination of Benefits (COB)" 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 "SECTION 8 - 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 available on Our website at **www.kp.org** or from Our Members Services Department (404) 261-2590 (local) or (888) 865-5813 (long distance).

## 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 the diagnoses of conditions which 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, and similar medical and surgical conditions of comparable severity, as well as 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 *Notices Regarding Your Health Plan Coverage* at the beginning of this EOC for further information.

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.

Those services which are listed on Our "Preventive Care Services Covered with No Copayments, Coinsurance or Annual Deductible requirements" list shall be considered preventive services (as covered under the "Preventive Visits and Services" provision of this EOC) and not Services covered under this "Maternity Care" provision to comply with the HRSA Guidelines.

## Physical, Occupational, Speech Therapy, Multidisciplinary Rehabilitation, Habilitative Services, and Cardiac Rehabilitation

Physical, Occupational, Speech Therapy, Multidisciplinary Rehabilitation, Habilitative, and Cardiac Rehabilitation require Prior Authorization before You receive such Services, as described under "Prior 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 include day or visit limits for Physical, Occupational, Speech Therapy, Multidisciplinary Rehabilitation, Habilitation, and Cardiac Rehabilitation. 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.

### *Habilitative Services*

We cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (Habilitative Services). Examples included therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, Applied Behavioral Analysis, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

### *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, Speech Therapy, Multidisciplinary Rehabilitation, Habilitative Services, 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.

## Treatment of Autism Spectrum Disorder

All covered Services described in this section to treat Autism Spectrum Disorder, as that term is defined below, are subject to Prior Authorization as described under "Prior Authorization for Services" at the beginning of this "SECTION 7 - Benefits" section.

The following terms, as used in this section, are defined below:

- **Autism Spectrum Disorder** means autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.
- **Applied Behavior Analysis (ABA)** means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Treatment of Autism Spectrum Disorder includes the following types of Services prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder:

- Habilitative or Rehabilitative Services, including Applied Behavior Analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. These covered Services are also described in the "Physical, Occupational, Speech Therapy, Multidisciplinary Rehabilitation, Habilitative Services, and Cardiac Rehabilitation" section.
- Services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
- Therapy Services for the Treatment of Autism Spectrum Disorder provided by a licensed or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist or marriage and family therapist.

Services for the treatment of Autism Spectrum Disorder are not Essential Health Benefits. Cost-sharing for Services that are not Essential Health Benefits shall not accumulate to the Out-of-Pocket Maximum Cost.

To the extent that therapy Services have a limited number of visits annually under this EOC, therapy Services provided solely for the treatment of Autism Spectrum Disorder shall not count towards such annual visit limitation.

### *Treatment of Autism Spectrum Disorder Limitations*

Services for the Treatment of Autism Spectrum Disorder shall be limited to:

- Assessments, evaluations or tests by a Participating Provider who is a licensed Physician or licensed psychologist;
- Medically Necessary covered Services for the Treatment of Autism Spectrum Disorder as prescribed by a Participating Provider. Such Participating Provider will be required to demonstrate that Covered Services are Medically Necessary at least annually.
- Coverage for ABA Services shall be unlimited with no annual maximum, however, copayments, coinsurance, and annual deductibles may still apply. Refer to the "Schedule of Benefits" section for more information.
- ABA Services are covered Services only if they are provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.

### *Treatment of Autism Spectrum Disorder Exclusions*

- Any Services described in this Treatment of Autism Spectrum Disorder that are not specifically required to be provided or arranged by Health Plan pursuant to an individualized family service plan, an individualized education plan as required by the federal Individuals with Disabilities Education Act, or an individualized service plan.
- Any Services that would be excluded under the General Exclusions for "Mental Health and Substance Abuse Disorder Services" except as explicitly covered under this Treatment of Autism Spectrum Disorder section.
- Any Services for the Treatment of Autism Spectrum Disorder for a member age twenty-one years old or older.

## 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 "SECTION 2 - How to Obtain Services" section. Emergency Services that You receive from Plan Providers are subject to the "SECTION 8 - General Exclusions, Limitations, Reimbursement of Health Plan, and Coordination of Benefits (COB)" section.

"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, (i) Your condition requires the use of Services that only a licensed ambulance can provide; (ii) the use of other means of transportation would endanger Your health; and (iii) You will receive Services at Your destination. 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 "SECTION 2 - How to Obtain Services" section.

### *Non-Ambulance Exclusion*

Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance in the circumstances described above), 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 definition of Emergency Medical Condition at Our designated **Kaiser Permanente Urgent 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. Services must be obtained at **Kaiser Permanente Urgent Care Centers** or at the Affiliated Community After-Hours Urgent Care Centers designated by Health Plan.

"After-Hours Urgent Care" is described under the "SECTION 2 - 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 "SECTION 2 - How to Obtain Services" section are subject to requirements regarding Prior Authorization as described under "Prior 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 "SECTION 7 - 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 Substance Abuse Disorder 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
- Hospital alternative Services (as further described below) such as partial hospitalization and intensive outpatient

psychiatric treatment programs, and

- Visits for the purpose of monitoring drug therapy.

### *Hospital Alternative Services*

If prescribed by a Plan Physician and subject to Prior Authorization, 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.

### *Inpatient Mental Health Services*

We cover Inpatient Services in a Plan Hospital. All inpatient Mental Health Services as described in this section require Prior Authorization as described under "Prior Authorization for Services" at the beginning of this section, and 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.

We cover the following Mental Health Services:

- Evaluation
- Crisis intervention
- Room and board, including a private room if medically necessary
- Treatment

Mental Health Services are provided by Medical Group Physicians and other Plan Providers such as psychologists, psychiatric social workers, certified nurse specialists, and professional counselors.

### *Mental Health Services Exclusions*

- Marriage and couples counseling are not covered;
- 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:
    1. Chronic psychosis, except that acute episodes due to a chronic psychotic condition is covered if the patient has been cooperative and has responded favorably to an ongoing treatment plan.
    2. 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;
- Developmental Disability;
  Outpatient drugs unless they are covered under "Pharmacy Services;"
- Services in a specialized facility, except to the extent required by law;
- 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; and
- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, developmental delay (when it is less than two standard deviations from the norm, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test) including, but not limited to, services for conditions related to autistic disease of childhood, hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems and mental retardation.

## Substance Abuse Disorder Services

### *Outpatient and Inpatient Detoxification Services*

We cover outpatient and inpatient Services to control the physiological complications of and withdrawal from alcohol and drug addiction subject to all of the terms and conditions of this Mental Health and Substance Abuse Disorder Services section.

We cover the following Services:

- Hospital Services.
- Medical treatment for withdrawal symptoms.
- Counseling (both individual and group).
- Inpatient Services subject to the terms and conditions for inpatient Mental Health Services.
- Inpatient specialized treatment programs.

### *Outpatient Substance Abuse Disorder Treatment Services*

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

We cover the following Services:

- Intensive outpatient programs;

- Outpatient Services subject to the terms and conditions for Outpatient Mental Health Services
- Counseling (both individual and group therapy visits);
- Medical treatment for withdrawal symptoms;
- Hospital alternative services, (as further described above) such as partial hospitalization and intensive outpatient psychiatric treatment programs; and
- Aftercare support visits, when provided as part of a covered program.

### *Inpatient Substance Abuse Disorder Treatment*

All patient treatment Services described in this section are subject to Prior Authorization as described under "Prior Authorization for Services" at the beginning of the "SECTION 7 - Benefits" section.

We cover the following Services:

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

### *Substance Abuse Disorder 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.

# 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 or otherwise defined by Health Plan;
- Vaccines and immunizations approved for use by the Federal Food and Drug Administration (FDA) that are not considered part of routine preventive care;
- 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.

### *Remote Order Prescription Processing*

Remote Order Prescription Processing is utilized only in Kaiser Permanente Pharmacies. Remote order processing is the processing of prescription or patient information from a location other than the location from which the prescription is received and does not include dispensing of a drug, but does include any of the following activities:
(1) Interpreting, analyzing, or clarifying prescriptions;
(2) Entering prescription or patient data into a data processing system;
(3) Transferring prescription information;
(4) Performing a drug regimen review;
(5) Performing a drug allergy review;
(6) Performing therapeutic interventions;
(7) Any combination of these functions.

By having Your prescriptions filled at one of the Kaiser Permanente of Georgia pharmacies You have agreed to have Your prescription processed via remote order processing.

## Prescribed Drugs

### *Outpatient Prescription Drugs*

We cover outpatient prescription drugs dispensed at a retail pharmacy. For a description of this benefit, please see the outpatient prescription drug benefit in the "Additional Benefits" section.

### *Preventive Drugs*

We cover at no cost the preventive medications listed below as required under the Affordable Care Act ("ACA"). **These preventive medications must be prescribed in writing by a Plan Physician** and obtained at a Kaiser Permanente Medical Center Pharmacy. They are subject to change based on federal requirements. and include, but may not be limited to, the following:

- Aspirin
- Oral Fluoride
- Topical Fluoride Varnish
- Folic Acid
- Iron Supplements
- Medications to prevent breast cancer
- Statins
- Bowel Preparation Medications
- Smoking cessation medications
- All Contraceptive drugs and devices listed on Our formulary and approved by the U.S. Food and Drug Administration as set forth in the HRSA Guidelines, including:
    - Contraceptive drugs

- Internally implanted contraceptives
- Injectable contraceptives and other time released drugs

For a complete list of covered preventive medications please refer to www.healthcare.gov/center/regulations/prevention.html for more information.

### *Manufacturer Coupons*

For outpatient prescription drugs and/or items that are covered under this Pharmacy Services section and obtained at a pharmacy owned and operated by Health Plan, You may be able to use **approved** manufacturer coupons as payment for the Cost Sharing that You owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of Your Cost Sharing for Your prescription.

When You use **an approved** coupon for payment of Your Cost Sharing, the coupon amount **and any additional payment that You make will accumulate to Your Cost Sharing Maximum Amount**. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at www.kp.org/rxcoupons.

## Step Therapy

Selected prescription drugs require step therapy. Step therapy defines how and when a particular outpatient prescription drug can be dispensed and establishes the specific sequence in which prescription drugs for a specified condition are deemed medically appropriate. Step therapy requiresthe use of one or more prerequisite drugs (first line agents), as identified through Your drug history, prior to the use of another drug (second line agent) when prescribed for Your condition. The step therapy process encourages safe and cost-effective medication use. Under this process, a "step" approach is required to receive coverage for certain medications. This means that to receive coverage You may first need to try a proven, cost-effective medication different than the one prescribed.

Your prescribing Plan Provider should prescribe a first-line medication appropriate for Your condition. If Your prescribing Provider determines that a first-line drug is not appropriate or effective for You, a second line drug may be covered if You qualify for a step therapy exception. Treatment decisions are always between You and Your Prescribing Provider.

Refer to Our formulary for a complete list of medications requiring step therapy. You may access Our forumlary at www.kp.org or 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).

## Step Therapy Exception and Appeal Process

A step therapy exception may be granted if Your prescribing Plan Provider's submits justification and supporting clinical documentation that demonstrates that another drug (second line agent) is Medically Necessary. The exception process may be initiated by contacting the Health Plan at the number located on the back of Your card. This exception process only applies to prescription drugs that are covered under this Plan.

### *Non-Urgent Exception*

We will respond to Your exception request within two (2) business days from the date such request is submitted in a nonurgent health care situation.

### *Urgent Exception*

We will respond to Your urgent exception request within 24 hours from the time such request is submitted in an urgent health care situation.

If We fail to respond within the stated time frame, Your step therapy exception will be deemed approved.

If Your exception request is denied, You may appeal Our decision. Our Appeals process is further decribed in SECTION 4 – Getting Assistance, Filing Claims, and Dispute Resolution.

Send Your Appeal to:

**Kaiser Permanente**
**Appeals Department**
**Nine Piedmont Center**
**3495 Piedmont Road, N.E.**
**Atlanta, GA 30305-1736**
**(404) 364-4862**

### *Non-Urgent Appeal*

We will respond to Your appeal within two (2) business days from the date of the appeal is submitted in a nonurgent health care situation.

### *Urgent Appeal*

We will respond to Your urgent appeal within 24 hours from the time of the appeal is submitted in an urgent health care situation.

If We fail to respond to Your appeal within the stated time frame, Your appeal will be deemed approved.

Nothing in this provision shall be construed to prevent Health Plan from (1) requiring a Member to try a generic equivalent prior to providing coverage for the equivalent branded prescription drug; (2) requiring a Member to try an interchangeable biological product prior to providing coverage for the

biological product; or (3) substituting a generic drug for a brand name drug.

## Review and Authorization

Certain prescription drugs require review and Prior Authorization prior to dispensing. Your Plan Physician must obtain this review and prior authorization. Our Pharmacy and Therapeutics Committee may periodically review and modify the list of prescription drugs requiring review and authorization, criteria for approval and other changes related to Our formulary.

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).

## Limitations

### *Off-Label Drugs*

An **Off-Label Drug** is one that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration.

We will cover Off-Label use of covered prescription drugs when prescribed for an individual with a life-threatening or chronic and disabling condition or disease. Coverage is also provided for Medically Necessary services associated with the administration of such a drug.

### *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 used in connection with cosmetic Services are not covered.
- Drugs and injectables for the treatment of sexual dysfunction disorders are not covered.
- Drugs and injectables for the treatment of involuntary infertility are not covered.

**Your Group may have purchased additional Pharmacy Services benefits. Refer to the "Additional Benefits Purchased by Your Group" in the "SECTION 10 – Additional Benefits and Schedule of Benefits" 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 "Prior Authorization for Services" at the beginning of this section.

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

We cover skilled inpatient Services at an approved Skilled Nursing Facility when prescribed by a Plan Physician and approved by Us. 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, Speech Therapy Multidisciplinary Rehabilitation, 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, subject to Prior Authorization 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 "SECTION 7 - 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 "SECTION 8 - General Exclusions, Limitations, Reimbursement of Health Plan, and Coordination of Benefits (COB)" section).
- Homemaker Services.
- Meals, personal comfort items and housekeeping services.
- Services administered by a person who normally lives in the home or who is a member of the family.
- Care that We determine 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 a Plan Provider:

- 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.

## Advanced Care at Home

Advanced Care at Home is a personalized, patient-centered program that provides care for patients with certain clinical conditions in their homes, or at another appropriate care location.

Advanced Care at Home services must be associated with an acute episode.

To receive Advanced Care at Home:

- The member must be referred into the Advanced Care program by the managing provider at a Plan emergency room setting, ACC/ CDU, or hospital.
- Advanced Care at Home requires Prior Authorization based on the member's health status, treatment plan, and home setting or another appropriate care location within the Service Area,
- The clinical condition must meet inpatient Medical Necessity criteria,
- The Member must consent to receiving Advanced Care described in the treatment plan,
- The care location, such as the member's residence, must have cell service.

Advanced Care at Home is provided through Plan Providers to provide the following services in the Member's home or appropriate care location:

- Daily virtual and as needed virtual visits are provided by the Plan Physicians who also coordinate the overall medical care of the patient.
- Home visits by RNs, paramedics, health aides, and other healthcare professionals in accordance with the Advanced Care at Home treatment plan and the provider's scope of practice and licensure.
- Communication devices to allow the Member to contact the medical command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable connection for communication, and a personal emergency response system alert device to contact the medical command center if the Member is unable to get to a phone.

Additional services covered under this benefit include:

- The following equipment necessary to ensure that You a monitored appropriately in Your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer.
- Mobile imaging and tests such as X-rays, ultrasounds, and EKGs.
- Safety items when Medically Necessary, such as shower stools, raised toilet seats, grabbers, long handled shoehorn, and sock aids.
- Meals when Medically Necessary while You are receiving Advanced Care at home.

In addition, cost sharing is waived for the following covered services and items when the services and items are prescribed during Your Advanced Medical Care at Home episode of care:

- Durable Medical Equipment.
- Medical Supplies.
- Member transportation to and from Plan facilities when Member transport is Medically Necessary.
- Emergency Department visits associated with this benefit.

The cost share is not waived and will apply to any services that are not part of Your Advanced Care at Home episode. (For example, readmission to the hospital after the Advanced Medical Care at Home episode is completed.)

For outpatient prescription drug cost shares, see the Outpatient Prescription Drug Rider in SECTION 10 – Additional Benefits and Schedule of Benefits.

Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient.

If a Member is admitted as an inpatient or to Advanced Care at Home directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share.

## Dental Services

We cover the following dental care Services:

- Dental care and appliances to repair accidental injury to mouth, jaw, and 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. 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).
- Surgical Services for the treatment of Temporomandibular Joint Dysfunction will be covered under the Outpatient surgery cost share as set forth in SECTION 10: Additional Benefits and Schedule of Benefits of this EOC.
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- General anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care are covered when provided in a hospital or outpatient facility designated by Health Plan for persons:
    - 7 years of age or younger, or
    - who are developmentally disabled, or
    - who are not able to have dental care under local anesthesia due to a neurological or medically compromising condition, or
    - who have sustained extensive facial or dental trauma.

### *Dental Service 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 provided under Our description of Dental Services; and
- All hospital Services for dental care, except as described under Dental Services.

## Durable Medical Equipment (DME)

All Durable Medical Equipment (DME) as described in this section requires Prior Authorization as described under "Prior 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, and blood glucose 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 this equipment for use in Your home (or an institution used as Your home), We cover the equipment subject to Prior Authorization, 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, continuous and non-continuous blood glucose monitors and supplies as described under "Pharmacy Services."
- Electronic monitors of bodily functions are not covered, except infant apnea monitors.
- Disposable supplies are not covered.
- Replacement of lost equipment (including, but not limit to theft) 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 "Prior 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, subject to Our Prior Authorization 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.
- Non-rigid 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.

## Pediatric Hearing Aids

For children up to age 19, We provide one Hearing Aid for each hearing-impaired ear when prescribed as Medically Necessary every 48 months up to the Benefit Maximum as specified in the "Schedule of Benefits." You need not obtain hearing aids for both ears at the same time, and the 48-month periods run separately for each ear. All Hearing Aids described in this section require prior authorization as described under "Prior Authorization for Services" at the beginning of this section.

If Your Hearing Aid(s) cannot adequately meet Your needs, and the Hearing Aid(s) cannot be adequately repaired or adjusted, We will replace the Hearing Aid(s), **once** during the 48-month period up to a separate Benefit Maximum equal to the initial Benefit Maximum as specified in the "Schedule of Benefits."

In this section, **Hearing Aid** means any nonexperimental and wearable instrument or device offered to aid or compensate for impaired hearing that is worn in or on the body. The term 'Hearing Aid' includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, nonimplanted bone anchored hearing aids, nonimplanted bone conduction hearing aids, and frequency modulation systems. Personal sound amplification products shall not qualify as Hearing Aids.

The Hearing Aid and all Medically Necessary Services and supplies count toward the Benefit Maximum including:

- The initial hearing aid evaluation;
- Fitting;
- Dispensing;
- Programming;
- Servicing, repairs, and follow-up maintenance;
- Adjustments;
- Ear mold impressions;
- Auditory training; and
- Probe microphone measurements to ensure appropriate gain and output.

A Member has the option of selecting a hearing aid through Health Plan providers or vendors We recommend, or through any licensed audiologist or licensed hearing aid dealer in Georgia.

### *Pediatric Hearing Aid Exclusions*

- Replacement parts for repair of a hearing aid are not covered except as outlined above.
- Replacements of lost, stolen, or broken hearing aids are not covered except as outlined above.
- Hearing aid batteries.
- Hearing aids for non-hearing-impaired ears.
- Hearing aids for Members who are 19 years old or older unless purchased separately by Your Group.

## 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.

## Infertility Services

All Infertility Services as described in this section require Prior Authorization as described under "Prior 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. These Services are covered only when received from Plan Providers.

**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*

These exclusions apply to fertile as well as infertile individuals:

- 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, including vasectomies, 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.
- Semen analysis for the treatment of infertility is not covered.
- Services related to conception by artificial means, such as, but not limited to those shown below, are not covered:
  - 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).

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

## Family Planning Services

We cover sterilization procedures including but not limited to 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*

- Artificial insemination.
- Other assistive reproductive technologies.
- Services to reverse voluntary, surgically induced infertility are not covered.

**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.**

## Reconstructive Surgery

All Reconstructive Surgery as described in this section require Prior Authorization as described under "Prior 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.

### *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 "Prior 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
- We approve a written referral for care at the facility in advance of Your treatment.

After the referral to a transplant facility by a Plan Provider, the following applies:

- If either We subsequently 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 Eligible Charges for the 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 and lodging expenses for any person, including a Member, is not covered within the Service Area. This does not apply to travel and lodging for a Member who has been approved for a transplant provided the transplant occurs outside the Service Area.
- 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.
- 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.

- Visual training.
- Low vision aids.

## Other Vision Services

Low Vision services are services provided to eligible Members with a significant loss of vision but not total blindness. The goal of services is to maximize the remaining usable vision for children with low vision who have visual impairments not fully treatable by medical, surgical interventions or conventional eyewear or contact lenses.

Coverage is limited to the following:

- Comprehensive low vision evaluation is covered at no charge.
- Low vision aids are covered at no charge.

### *Other Vision Services Exclusions*

- Laser Vision Correction and Progressive Lens Options.
- Replacement of lenses, frames or contacts.
- Orthoptics, vision training or supplemental testing.

Items not covered under the contact lens coverage:

- Insurance policies or service agreements
- Additional office visits for contact lens pathology
- Contact lens modification, polishing or cleaning

The Cost Sharing You pay for covered Vision Services counts toward Your Cost Sharing Out-of-Pocket Maximum shown on the "Schedule of Benefits" section at the end of this EOC.

## Chiropractic Services

### *Spinal Manipulation*

We cover Services for Spinal Manipulation. Services must be provided from sources designated by Health Plan. You do not need a referral from Your Kaiser Permanente personal physician for covered Services for Spinal Manipulation. Your plan may include visit limits. Refer to the "Schedule of Benefits" section at the end of this EOC for more information.

## Clinical Trials

We cover Services You receive in connection with a clinical trial if all of the following conditions are met:

- We would have covered the Services if they were not related to a clinical trial.
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - A Plan Provider makes this determination.
  - You provide Us with medical and scientific information establishing this determination.
- If any Plan Providers participate in the clinical trial and will accept You as a participant in the clinical trial, You must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where You live.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
  - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
  - The study or investigation is a drug trial that is exempt from having an investigational new drug application.
- The study or investigation is approved or funded by at least one of the following:
  - The National Institutes of Health.
  - The Centers for Disease Control and Prevention.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare & Medicaid Services.
  - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
  - It is comparable to the National Institutes of Health system of peer review of studies and investigations.
  - It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, You will pay the Cost Sharing You would pay if the Services were not related to a clinical trial. For example, see "Schedule of Benefits" for the Cost Sharing that applies to hospital inpatient care.

### *Clinical Trials Exclusions*

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in Your direct clinical management of Your cancer or life-threatening medical condition.

## Treatment for a Terminal Condition

The following term in this EOC section have the following definitions:

**Terminal Condition** means *any disease, illness, or health condition that a Plan Physician has diagnosed as expected to result in death in 24 months or less*.

We cover Services for treatment of a Terminal Condition when such Services are prescribed by a Plan Physician and are Medically Necessary and You or Your delegated representative (who is authorized to consent on Your behalf) consent to receipt of such Services. We shall determine that Services are Medically Necessary when the prescribed Services, including but not limited to any drug or device, are (1) consistent with best practices for treatment of the Terminal Condition; and (2) supported by peer-reviewed medical literature.

### *Treatment for a Terminal Condition Exclusion*

Services, including but not limited to drugs or devices, regardless of where actually prescribed, dispensed or administered, which if prescribed, dispensed or administered in the State of Georgia would constitute assisted suicide in violation of applicable federal or state law.

# SECTION 8 - 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 "SECTION 10 - Additional Benefits and Schedule of 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 "SECTION 4 - Getting Assistance, Filing Claims, and Dispute Resolution" Section of this EOC.

2. **Alternative Services**

We do not cover alternative services, including but not limited to: Vax-D, massage therapies, acupuncture therapy, vitamins and supplements and hypnotherapy.

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.

**5. Services while Incarcerated in the Criminal Justice System**

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.

**6. Services while Confined in a Non-Plan Mental Health Institution**

Services provided, ordered, or arranged by a mental health institution where the Member is confined or resident, unless the Services are covered Emergency Services as described in this EOC.

7. **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.
- 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.

**8. 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.

**9. 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.

**10. Employer requirements**

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

**11. 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 the Service is to be provided;
- It cannot be legally performed or marketed in the United States without FDA approval and it does not have 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; except as specifically provided in "Clinical Trials" section
- 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.

This exclusion does not apply to Services covered under "Clinical Trials" in the "SECTION 7 - Benefits" section.

**12. Eye surgery for Refractive Defects of the Eye**

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

**13. Excess Charges from non-Plan Providers**

Charges from non-Plan Providers that exceed Eligible Charge(s).

**14. Non-Covered Services Ordered by Non-Plan Providers**

Any covered Service(s) ordered by a non-Plan Provider (such as laboratory and/or radiology services) that constitute(s) follow-up care, continuing care or is otherwise part of a course of care provided or arranged by a non-Plan Provider that Health Plan determines is not covered under the terms of this Agreement, regardless of whether or not such covered Services are provided by a Plan Provider.

**15. Government agencies**

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

**16. Intermediate Care**

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

**17. Items and Services that are Not Health Care Items and Services**

- Teaching manners and etiquette.
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning.
- Items and services for the purpose of increasing academic knowledge or skills.
- Teaching and support services to increase intelligence.
- Academic coaching or tutoring for skills such as grammar, math, and time management.
- Teaching You how to read, whether or not You have dyslexia.
- Educational testing.
- Teaching art, dance, horse riding, music, play or swimming.
- Teaching skills for employment or vocational purposes.
- Vocational training or teaching vocational skills.
- Professional growth courses.
- Training for a specific job or employment counseling.
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under the "Hospital Care Benefit," "Outpatient Services," "Home Health Care," "Hospice Care," and "Skilled Nursing Facility" in the "SECTION 7 – Benefits" section.

**18. Obesity**

All Services and drugs related to the treatment of obesity. Certain health education classes and nutrition counseling, and Services to diagnose the causes of obesity or treatment of diseases resulting from obesity are covered.

**19. Personal Comfort Items**

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

**20. 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.

**21. 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.

**22. Services for Which No Charge is Normally Made**

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

**23. 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.

**24. 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.

**25. Services that Are the Subject of a non-Plan Provider's Notice and Consent**

Amounts owed to non-Plan Providers when You or Your authorized representative consent to waive Your right against surprise billing/balance billing (unexpected medical bills) under applicable state or federal law.

**26. Transportation and lodging expenses**

Transportation and lodging expenses for any person, including a Member, except with respect to a transplant that occurs outside the Service Area.

**27. Surrogacy Services**

Surrogacy Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Refer to "Surrogacy Arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about Your obligations to Us in connection with a Surrogacy Arrangement, including Your obligations to reimburse Us for any Services We cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

# 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, or
- 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*.

### *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 Owed to Health Plan

**Injuries or illnesses where another party or insurer is liable for the injury or illness:**

- **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 "SECTION 9 - 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 non-Plan Providers, 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, award, or other amount ("Recovery") You receive whether by compromise or otherwise, from or on behalf of any other liable party or insurer for the value of Services provided and expenses covered by both Health Plan and other party recovery. You must hold in trust, in a specifically identifiable account 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 amount paid for applicable Cost Share, non-medical items or expenses for future medical care. The amount of reimbursement due the Plan is not limited by or subject to the Out-Of-Pocket Maximum. 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.

Benefits payable under the Plan will be secondary to benefits provided or required by any automobile insurance, including medical payments coverage, personal injury protection, or no-fault coverage regardless of any election or designation to the contrary.

### *Member's Cooperation Required*

You must cooperate in protecting Health Plan's right of Recovery and/or interests to payment or reimbursement 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 or any arrangement or agreement between Yourself and a third party for payment or reimbursement of cover Services no later than 30 days after submitting or filing such claim or legal action or immediately upon entering into a third party arrangement or agreement. 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:

**The Phia Group, LLC.**
**40 Pequot Way**
**Canton, MA 02021**
**Phia Call center: (888) 397-0173**
**Phia Fax: (781) 848-1154**

### *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 any amount owed to Us that exceeds the Recovery shall be canceled. If there is no Recovery (other than due to Your failure to pursue 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 for Services provided by Kaiser Providers.

This "**Injuries or illnesses where another party or insurer is liable for the injury or illness**" section does not affect Your obligation to pay any applicable Cost Share for these covered Services. The amount of reimbursement due to the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

### *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.

### *Workers' Compensation or Employer's Liability*

If You suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, We will provide Services even if it is unclear whether You are entitled to a payment or settlement under the law. You have an obligation to reimburse Us to the extent of a payment or any other benefit, including any amount You receive as a settlement under the law.

## Services arranged by and to be paid for or reimbursed by a Third Party

If You enter into any arrangement or agreement including, but not limited to, a Surrogacy Arrangement, and You or any other payee are entitled to receive payments or other compensation under the arrangement or agreement, You must reimburse Us for covered Services You receive to the maximum extent allowed under law.

#### *Surrogacy Arrangements – Traditional and Gestational Carriers*

If You enter into a Surrogacy Arrangement, whether traditional or gestational, and You or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, You must reimburse Us for covered Services and/or You must ensure We are reimbursed for covered Services You receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount We collect will not exceed the payments or other compensation You and any other payee are entitled to receive under the Surrogacy Arrangement.

This section applies if You are impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and includes both traditional gestational surrogacy. Note: This "Surrogacy Arrangements – Traditional and Gestational Carriers" section does not affect Your obligation to pay any applicable Cost Share, or other amounts You are

required to pay for these Services. After You surrender a baby to the legal parents, You are not obligated to reimburse Us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services under this Health Plan, You automatically assign to Us Your right to receive payments that are payable to You or any other payee under the Surrogacy Arrangement or other agreement, regardless of whether those payments are characterized as being for medical expenses. To secure Our rights, We will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy Our lien. The assignment and Our lien will not exceed the total amount of Your obligation to Us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement or agreement, You must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement.
- Names, addresses, and telephone numbers of any escrow agent or trustee.
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive.
- A signed copy of any contracts and other documents explaining the arrangement.
- Any other information We request in order to satisfy Our rights.

You must send this information to:

**Surrogacy Other Party Liability Supervisor**
**The Phia Group, LLC.**
**40 Pequot Way**
**Canton, MA 02021**
**Phia Call center: (888) 397-0173**
**Phia Fax: (781) 848-1154**

You must complete and send Us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Us to determine the existence of any rights We may have under this "Surrogacy Arrangements – Traditional and Gestational Carriers" section and to satisfy those rights. You may not agree to waive, release, or reduce Our rights under this "Surrogacy Arrangements – Traditional and Gestational Carriers" section without Our prior, written consent.

If Your estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, Your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to Our liens and other rights to the same extent as if You had asserted the claim against the third party. We may assign Our rights to enforce Our liens and other rights.

## Coordination of Benefits (COB)

**This EOC is subject to coordination of benefits rules which apply when You have health benefits coverage under more than one Plan.** The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. You should submit claims with each Plan.

**Definitions**

For purposes of this section, terms are defined as follows:

- **Plan**: The term includes (a) An insurance plan issued to an individual/non-group or a group; or a self-insured group health plan providing benefits in the form of reimbursement or services for medical care or treatment/items; (b) Governmental benefits as permitted by law, except for Medicaid, Medicare, and Medicare supplement policies; and (c) Medical benefits coverage under any form of group or individual automobile insurance.

  Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.
- **Primary Plan:** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan:** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.
- **Order of Benefit Determination Rules**: The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

**Order of Benefit Determination Rules**

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

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

- A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan unless the provisions of both Plans state that the complying Plan is primary. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one that applies**:**

    - The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan.

      However, if You are a Medicare beneficiary, and, as a result of federal law, Medicare is secondary to the Plan covering You as a dependent and primary to the plan covering You as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the Plan covering the You as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering You as a dependent is the Primary Plan.

    - If You are a dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the Calendar Year as an enrollee or employee.

    - If You are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:

        - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

        - then, the Plan of the parent with custody of the child;

        - then, the Plan of the spouse of the parent with custody of the child;

        - then, the Plan of the parent not having custody of the child; and

        - finally, the Plan of the spouse of the parent not having custody of the child.

- The Plan that covers You as an active employee (or as that employee's dependent) shall be the Primary Plan and the Plan that covers You as a laid-off or retired employee (or as that employee's dependent) shall be the Secondary Plan. If the other plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- The Plan that covers You under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers You as an active employee or retiree (or as that employee's dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- If one of the Plans that covers You is issued out of the state whose laws govern this Plan and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered You for the longer period of time shall be the Primary Plan.

**Effect on the Benefits Payable under this Plan**

- If this Plan is the Primary Plan, the amount this plan pays for Covered Expenses will be determined without regard for the benefits payable under any other Plan.
- When this Plan is the Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In

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

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

- Benefits payable under the Plan will be secondary to benefits provided or required by any group or individual automobile insurance, including medical payments coverage, personal injury protection, or no-fault coverage regardless of any election or designation to the contrary.

**Overpayment Recoveries**

If We pay for Covered Services that should have been paid by the Primary Plan or if Our payment exceeds what We are obligated, We have the right to recover such overpayments and may seek, in Our sole discretion, such recoveries from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or private or government payer. You agree to provide Us with information We determine necessary to pursue Our right of recovery.

**Right to Receive and Release Needed Information**

We may obtain information without Your consent from and release information to any other Plan with respect to You in order to coordinate Your benefits pursuant to this section. You must provide Us with any information We request in order to coordinate Your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, You will be advised that the "other coverage" information, (including an explanation of benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 45 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

# SECTION 9 - Definitions

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

**Ancillary Service:** Services that are:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner.
- Items and services provided by assistant surgeons, hospitalists, and intensivists.
- Diagnostic services, including radiology and laboratory services.
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-Plan Provider satisfies the notice and consent requirements under federal law.

**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:**

**(Embedded)** the amount of Eligible Charges You must pay for certain covered Services each Plan Year before We pay any amount for those Services. The Annual Deductible is shown in the "Schedule of Benefits" section. The Annual Deductible applies separately to each Member during each Plan Year.

**(Coverage with Dependents)** Also sometimes referred to as "Aggregate Deductible," 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 owed for 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 Eligible Charges 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 and pay Eligible Charges during the last three months of the Plan Year towards satisfaction of Your Annual Deductible, then that amount shall be applied toward satisfaction of Your Annual Deductible for that the next Plan Year as required by applicable state law.

**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 or a Dependent must pay at the time certain covered Services are received from Plan Providers or Plan Physicians as described in the "Schedule of Benefits" section.

**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.

**Cost Sharing:** The amount up to the Cost Sharing Out-of-Pocket Maximum You are required to pay under this Agreement for a covered Service, for example: The Annual deductible, Copayment, or Coinsurance.

**Cost Sharing Out-of-Pocket Maximum:** The maximum amount of Cost Sharing You and/or Your Family must pay each Year for covered Services provided by Plan Providers. Once the Cost Sharing Out-of-Pocket is reached, We will pay 100% of further Eligible Charges incurred by You and/or Your Family for covered Services during the remainder of the Year. Keep Your receipts to verify the Cost sharing You and/or Your Family have paid.

Amounts in excess of Eligible Charges, as well as Cost Sharing for Non-Essential Health Benefits, do not count toward the Cost Sharing Out-of-Pocket Maximum. Some examples of Non-Essential Health Benefits are listed here:

- Acupuncture Services;
- Chiropractic care (excluding services for spinal manipulation);
- Durable medical equipment;

- Adult Dental Services;
- Hearing Aid;
- Infertility Treatment Services;
- Prosthetics and orthotics;
- Continuing or follow-up treatment outside the Service Area;
- Morbid Obesity Services;
- Optical Exams and Optical Hardware for Adults.

Please refer to the "Schedule of Benefits" section for additional information to determine if a Service is covered.

**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 for each month in the Plan Year.

**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 "SECTION 7 - 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 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.
- For Services received from Plan Providers or other contracted providers, the amount the Plan Provider has agreed to accept as payment.
- For Emergency Services received from non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services under state or federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process.
- For all other Services received from non-Plan Providers (including Post-Stabilization Services that are not Emergency Services under state or federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the non-Plan Provider and Us or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Us based on objective criteria (such as the fee schedule for the Georgia State Board of Worker's Compensation).

**Emergency Medical Condition:** A medical condition including a mental health condition or substance use disorder, 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:

- An appropriate medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act (section 1867 of the Social Security Act) ("EMTALA")) that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, 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, or Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA (or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department) to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
- Post-Stabilization Care furnished by a non-Plan Provider (including a nonparticipating emergency facility) is covered as Emergency Services when state or federal law applies AND:
  - Your attending non-Plan Provider determines that You are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider within a reasonable travel distance, taking into account Your medical condition; or,
  - You (or Your authorized representative) are not in a condition to receive, and/or to provide consent to, the non-Plan Provider's notice and consent form, in accordance with applicable state law pertaining to informed consent as determined by Your attending non-Plan Provider using appropriate medical judgment.

**Note:** Once Your condition is stabilized, covered Services that You receive are Post Stabilization Care and not Emergency Services EXCEPT as described above and are subject to all of the terms and conditions of this EOC including but not limited to Prior Authorization.

**Essential Health Benefits:** Essential Health Benefits are certain services that are required to be included under the Affordable Care Act. The services considered to be Essential Health Benefits are determined by state and federal regulators as set forth in applicable law and implementing regulations and are available for Eligible Individuals.

**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 one eligible employee, 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. To be considered an "eligible employee," the individual must meet Our definition of "eligible employee."

**Health Plan:** Kaiser Foundation Health Plan of Georgia, Inc., a Georgia nonprofit corporation, licensed as a health maintenance organization by the Georgia Department of Insurance to underwrite Your coverage described in this EOC.

**Independent Freestanding Emergency Department:** A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

**Kaiser Permanente:** The direct service health medical program conducted by Health Plan, Kaiser Foundation Hospitals and Medical Group, together.

**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. (TSPMG).

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

**Medical Record Number (MRN):** An individual number assigned by Us to a Member to identify a Member's medical records and membership information.

**Medically Necessary**: Our determination that a covered 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 locally or nationally; and/or (d) any other relevant factors reasonably determined by Us. Unless otherwise required by law, We decide if a covered Service is Medically Necessary. You may appeal Our decision as set forth in the "SECTION 4 - Getting Assistance, Filing Claims, and Dispute Resolution" Section. The fact that a Plan Provider has prescribed, recommended, or approved an item or service does not, in itself, make such item or service 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, Affiliated Community Physician, hospital physician, or licensed provider, 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, Kaiser Foundation Hospitals or Health Plan contracts to provide Services to Members, listed in the Physician Directory.

**Plan 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.

**Post-Stabilization Care:** Means 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 ***only*** when (1) it is considered to be Emergency Services under state or federal law (without Prior Authorization) or, (2) We determine that such Services are Medically Necessary pursuant to a request for Prior Authorization for the Service.

**Premium:** Periodic membership charges paid by or on behalf of each Member usually on a monthly basis for covered Services. Payment of the Premium is a condition precedent to the

provision and/or arrangement of Services and is in addition to any other charges You are required to pay for covered Services.

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

**Service Area:** The geographic area 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, supply, equipment or device as described in the "SECTION 7 - Benefits" section, which You have not exhausted if the benefit is limited. When a service is excluded (not covered), all services that are associated with the excluded service are also excluded even if they would be otherwise covered under this EOC.

**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 an intermediate care facility, a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in activities of daily living.

**Spouse:** The person to whom You are legally married under applicable law.

**Stabilize:** To provide the medical treatment for an 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 to a Plan Provider. 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 monthly Premium on or before the due date.

**Surrogacy Arrangement**: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the individual receives payment for being a surrogate. For the purposes of this EOC, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

## 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.

GA07EOC-RDR INTRO 08/06

# Domestic Partner

This Addendum applies to the Kaiser Permanente (Traditional (HMO) Plan Evidence of Coverage; the Kaiser Permanente Added Choice Plan Evidence of Coverage); and the Kaiser Permanente Multi-Choice Plan, (each of which shall be referred to as an "EOC")) shall be in effect during the term of the EOC.

For purposes of this EOC, a Dependent includes a Domestic Partner. A Domestic Partner is a person who meets all of the eligibility requirements of the Group.
A Domestic Partner is a person who meets all the requirements shown on Health Plan's Declaration of Domestic Partnership (the "Declaration").

Health Plan may require proof of the establishment and/or continued existence of a Subscriber's domestic partnership and Group and Subscriber agree to provide such proof promptly upon request.
A person must meet and continue to meet throughout the term of this Agreement all of the Domestic Partner requirements pursuant to the group health plan eligibility requirements Declaration in order to enroll and continue such enrollment. An accurate and completed Declaration form must be submitted to Health Plan.

A Domestic Partner may not be eligible for continued enrollment after the Subscriber's enrollment in Group's group health plan terminates or changes, as set forth in this Agreement. For example, a Domestic Partner may not be eligible for continued enrollment in Health Plan pursuant to Subscriber's enrollment under COBRA.

Domestic Partnership Standards

We attest:

- We have **Lived Together** (see definition below) in the same household for a period of at least six months;
- We have a committed personal relationship with each other that is mutually interdependent and intended to be lifelong;
- We agree to be jointly obligated and responsible for the **Necessities of Life** (see definition below) for each other;
- We are not legally married or legally separated from another person;
- We are at least 18 years of age;
- We are competent to enter into a contract;
- We are not related by blood closer than would legally bar marriage under the laws of the state of Georgia;
- We are each other's sole domestic partner;
- We have not been a party to a domestic partnership that was terminated within six months before the date of the Declaration, except if that other domestic partnership was terminated by death; or if such earlier domestic partnership had been acknowledged under provisions of this section, that notice of termination of such earlier domestic partnership was provided to the employer and applicable state, county, local or municipal department responsible for Domestic Partners Registry, if any;
- We agree to promptly inform the employer of any changes in the status of this Domestic Partnership; and

- We hereby make application to register as Domestic Partners pursuant to these terms and conditions.
- We agree to file a termination of Domestic Partnership with the employer within 30 (thirty) days if any of the above facts change;

**Definitions:**

**Live Together** means that two people claiming Domestic Partnership share the same primary, regular and permanent residence. It is not necessary that the legal right to possess the residence be in both names. Whether the relationship between these two people is or is not sexual is in no way relevant for the purposes of determining eligibility under this Declaration.

**Necessities of Life** means the cost of basic food, shelter, clothing and medical care. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible and obligated for the cost.



## Outpatient Prescription Drugs

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

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

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

**Preferred Brand Prescription 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 Prescription Drug** is a prescription drug that is not listed by Us as a drug preferred or favored to be dispensed.

**Specialty Prescription Drug** is a prescription drug that is very high cost and generally biologically derived.

We cover the drugs and supplies described below when prescribed by a Plan Physician or dentist as described in this rider unless an exclusion or limitation applies.

You must obtain these drugs from a Kaiser Permanente Medical Center Pharmacy or at a community pharmacy, which is any pharmacy contracted with and designated by Health Plan that is not located in a Kaiser medical center or facility.

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 (a) the days supply per prescription as listed in the "Schedule of Benefits" section or (b) 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, 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.

**Outpatient Prescription Drug Coverage**

Drugs and supplies covered under this rider include the following:

- Drugs approved by the Food and Drug Administration (FDA).
- Drugs for which a prescription is required by law.
- Prescription drugs on the Kaiser Permanente drug formulary.
- Oral medications for the treatment of diabetes.
- Insulin.
- Disposable needles and syringes for injecting prescribed drugs.
- Glucose ketone and acetone test strips or tablets.
- Oral and nasal inhalers.
- Compounded preparations which must be prepared by a pharmacist.
- 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.
- Outpatient prescription drugs and injectables for the purpose of weight loss or the treatment of obesity.
- Outpatient prescription drugs and injectables for the treatment of sexual dysfunction disorders

**Special note about Our drug formulary**

The Kaiser Permanente drug formulary is a list of prescription drugs that have been approved by Our Pharmacy and Therapeutics Committee for Our Members. Our Pharmacy and Therapeutics Committee, which is comprised of Plan Physicians and other Plan Providers, selects prescription drugs for the drug formulary based on a number of factors, including but not limited to safety and effectiveness as determined from a review of medical literature and research. The Pharmacy and Therapeutics Committee meets several times each year to consider adding and removing prescription drugs on the drug formulary. Changes can occur to the drug formulary list due at any time to:

- New clinical studies indicating additional or new evidence that can either benefit the Member's outcome or that identified potential harm to the Member.
- A Brand Name Drug loses its patent and generic drugs equivalent becomes available; or
- A Brand Name Drug becomes available over the counter in which case the drug will not be covered under this rider even if it was covered previously.
- Multiple Similar Drugs become available such as other drugs within a specific drug class (for example anti-inflammatory drugs, anti-depressants or corticosteroid asthma inhalers).
- Multiple Similar Drugs become available over the counter within a specific drug class (for example non sedating antihistamines).

Similar Drugs mean drugs within the same drug class or type that are therapeutic/clinically equivalent drugs and can be expected to produce similar therapeutic outcomes for a disease or condition.

If You request a non-formulary drug – when Your Plan Physician does not indicate that the non-formulary drug is Medically Necessary You will be responsible for the full cost of that drug.

However, if Your Plan Physician documents that:

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

an exception process is available to Your Plan Physician to seek permission to prescribe a Medically Necessary non-formulary drug for You. In that case, if the exception is approved, Your Plan Physician's request is approved, Your standard prescription drug Copayment, Coinsurance and deductibles would apply. This formulary exception process does not apply to Your dentist. In order to be covered at Your prescription drug Copayment, Coinsurance and deductible all prescriptions written by Your dentist must be included on the Kaiser Permanente drug formulary.

**Manufacturer Coupons**

For outpatient prescription drugs and/or items that are covered under this Pharmacy Services section and obtained at a pharmacy owned and operated by Health Plan, You may be able to use approved manufacturer coupons as payment for the Cost Sharing that You owe as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of Your Cost Sharing for Your prescription.

When You use an approved coupon for payment of Your Cost Sharing, the coupon amount and any additional payment that You make will accumulate to Your Cost Sharing Maximum Amount. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at www.kp.org/rxcoupons.

**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) 434-2008. Home delivery prescriptions must be paid for in advance by credit card.

You may order up to a 90-day supply unless Your prescription specifies a different supply amount. You are responsible for paying the applicable Copayments, Coinsurance and deductibles. There is no shipping charge and no additional fees for home delivery prescriptions.

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 described 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 Limitations and Exclusions***

The following items are excluded from the outpatient prescription drug coverage, under this rider, in addition to those set forth in the "SECTION 8 - General Exclusions and Limitations" section of this EOC:

- Drugs and supplies other than those described 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 even if such drugs and supplies would be covered under this rider.
- 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.
- Immunizing agents, biological sera, blood or blood plasma are not covered.
- Except for the treatment of Alopecia areata, 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, and those listed in the drug formulary, drugs available without a prescription or for which there is a nonprescription equivalent available are not covered.
- Drugs in classes determined by the Pharmacy and Therapeutics Committee to warrant restriction to certain age groups.

GA25HMOAB-RX 08/24 (25RXTKPPN)

## 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*

These exclusions apply to fertile as well as infertile individuals:

- 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 “Outpatient Prescription Drug Rider” above in this “Additional Benefits Purchased by Your Group” section for more information.

- Ovum transplants are not covered.
- Gamete intrafallopian transfer (GIFT) is not covered.
- Zygote intrafallopian transfer (ZIFT) is not covered.
- Services for any person who is not a Member are not covered.
- Services for embryo fertilization and transfer relating to iatrogenic infertility.
- Preserving and storing sperm, eggs and embryos are not covered.

GA23HMOAB-INFTX 05/22 (23HMOINTLGII)

## Chiropractic Services

We cover Services for Spinal Manipulation. Services must be provided from sources designated by Health Plan. You do not need a referral from your Kaiser Permanente personal physician for covered Services for Spinal Manipulation. Your plan may include visit limits. Refer to the "Schedule of Benefits" section at the end of this Evidence of Coverage for more information.

The Cost Sharing you pay for covered Spinal Manipulation Services counts toward your Cost Sharing Out-of-Pocket Maximum shown on the "Schedule of Benefits" section at the end of this Evidence of Coverage.

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 Evidence of Coverage 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 Resources 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 (14HMOCHRLG)

## Adult Hearing Aids

Your Plan may or may not include the Adult Hearing Aids Benefit. Refer to the "Schedule of Benefits" section for more

information on whether Your Plan includes this Benefit.

We cover the following services for individuals age 19 and older,:

- Hearing tests to determine the need for hearing correction.
- Hearing tests to determine the appropriate hearing aid and follow up care.
- Internally implanted hearing devices when medically necessary.
- Visits to verify that the hearing aid conforms to the prescription.
- Visits for fitting, counseling, adjustment, cleaning, and inspection.

We provide an allowance toward the price of a hearing aid for each ear when prescribed by a Plan Provider, but only if we have not covered (under this or any other EOC) a hearing aid for that ear within the previous 36 months. We will cover hearing aids for both ears only if both are required to provide significant improvement that is not obtainable with only one hearing aid. You need not obtain both aids at the same time, and the 36 months runs separately for each ear.

An allowance is applied toward the total expenses of an item that is covered. You may only use you allowance one time, which is at the time you place your initial order for your hearing aid(s). If the cost of the item you select exceeds the allowance, you will pay the difference. A “hearing aid” means an electronic device worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold if necessary.

We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types of models of hearing aids furnished by the provider or vendor.

**Hearing Aids Exclusions**

- Hearing aids prescribed or ordered before you were a Member are not covered.
- Replacement parts for repair of a hearing aid are not covered.
- Replacement of lost, stolen or broken hearing aids are not covered.
- Hearing aid batteries are not covered.
- Repair of hearing aids after the end of the one-year warranty period is not covered.
- Services for hearing aids are covered under this benefit only when received from Plan Providers.

## Class III Obesity

Class III obesity, formerly known as morbid obesity, is a complex chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions (as defined by the Cleveland Clinic).

Some obesity-related health conditions include hypertension, cardiopulmonary conditions, sleep apnea, and diabetes.

We cover the following Services related to the diagnosis and treatment of Class III Obesity, if prescribed or performed by a Plan Provider. Surgical treatment must be authorized as described under "Prior Authorization for Services" section in "SECTION 7 – Benefits" of this EOC.

- Office visits for the medical treatment of Class III Obesity.
- Nutritional assessment and counseling.
- Behavioral assessment and counseling.
- Very low-calorie diets or meal-replacement plans.
- Surgical treatment provided, prescribed, , or directed by a TSPMG Physician, and authorized by Health Plan's Quality Resource Management Program.
- Outpatient prescription drugs for the treatment Class III Obesity have been purchased by Your Group. Refer to the "Outpatient Prescription Drugs Rider" above in this "Additional Benefits Purchased by Your Group" section for more information.

***Class III Obesity Exclusions***

The following Services are excluded from this Class III Obesity coverage:

- Chiropractic Services are not covered except where specifically noted to the contrary in this Evidence of Coverage.
- Alternative medicine treatments are not covered, unless covered under another benefit.
- Services rendered or billed by commercial weight loss centers are not covered.
- Cosmetic surgery related to bariatric surgery or weight loss is not covered.

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

GA25HMOAB-MOB 08/24 (25MORBHMON_D)

# Schedule of Benefits

## For WILLIAMS-SONOMA, 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 Plan 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, including Prior Authorization penalties, 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 month 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 Plan 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 Plan 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 Cost Sharing Out-of-Pocket Maximum under this EOC are on a Plan Year basis. Any amounts that You paid in the same Plan Year, under a prior EOC from the same employer Group, toward the Annual Deductible or any other deductible and Cost Sharing Out-of-Pocket Maximum shall carry-forward and count toward satisfaction of the deductibles and Cost Sharing Out-of-Pocket Maximum shown in this EOC.

The annual dollar, day and visit limits, deductibles, Annual Benefit Maximum and Cost Sharing Out-of-Pocket Maximums are based on Plan Year. Your Cost Sharing for Services is due at the time of your visit. For items ordered in advance, you pay 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 "SECTION 9 - Definitions" section.

All covered Services are subject to the Annual Benefit Maximum, Annual Deductibles and Maximum Benefit While Covered unless otherwise noted below and in this EOC. 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 count toward satisfaction of the Cost Sharing Out-of-Pocket Maximums. Refer to the definitions of "Cost Sharing Out-of-Pocket Maximum" shown in the "SECTION 9 - Definitions" section.

Amounts You pay for the following Services do not count toward the Cost Sharing Out-of-Pocket Maximum: Services for which You pay a Copayment such as Applied Behavorial Analysis, private duty nursing, non-surgical dental treatment, preventive dental care, infertility treatment, 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.

All covered Services are subject to the Annual Deductible except for those preventive Services identified as exempt from the Annual Deductible in the "Preventive Visits and Services" subsection in the "SECTION 7 – Benefits" section of this EOC and routine prenatal visits. We added "(Not subject to Annual Deductible)" in this "Schedule of Benefits" to show when the Annual Deductible does not apply. Service fees, penalties, and charges in excess of Eligible Charges do not count toward satisfaction of the Annual Deductible or the Cost Sharing Out-of-Pocket Maximum.

For all other Services, You must pay full Eligible Charges when You receive the Service, until You meet the Annual Deductible. The only payments that count toward the Annual Deductible are those You make for Services that are subject to the Annual Deductible, but only if the Services would otherwise be covered.

After You meet the Annual Deductible, You pay the applicable Copayment or Coinsurance for these covered Services for the rest of the Plan Year, subject to the limits described under "Cost Sharing Out-of-Pocket Maximum" in this "Schedule of Benefits". Any amounts You pay toward the Annual Deductible apply toward the annual Cost Sharing Out-of-Pocket Maximum. Also, any Copayments or Coinsurance You pay for covered Services apply toward the annual Cost Sharing Out-of-Pocket Maximum.

Once You have received Services and We have processed the claims for Services rendered, We will send You an *Explanation of Benefits* (EOB) that explains Services You received, the cost of those Services and the payments that were made for the Services. It will also include information regarding what portion of the payments were applied to Your Annual Deductible or Cost Sharing Out-of-Pocket Maximum amounts. We recommend that You also maintain Your receipts for Services received for tracking Your Annual Deductible and Cost Sharing Out-of-Pocket Maximum.

## SCHEDULE OF BENEFITS

| | |
|---|---|
| Annual Deductible<br>(Applies to Cost Sharing Out-of-Pocket Maximum)<br>(Some specific benefits may have a deductible) | Single: $350<br>Family: $700 |
| Cost Sharing Out-of-Pocket Maximum | Single: $2,000<br>Family: $4,000 |
| Coinsurance (unless otherwise specified in this EOC) | Plan pays 80% after Annual Deductible |

| **Covered Services** | **Health Plan Pays** |
|---|---|
| **OFFICE SERVICES** | |
| Primary care visits | $25 Copayment |
| Specialty care visits | $50 Copayment |
| Laboratory Services | Plan pays 80% after Annual Deductible |
| X-rays and other routine radiology Services | Plan pays 80% after Annual Deductible |
| Diagnostic Mammogram after screening for the treatment of cancer. | Plan Pays 100%<br>(Annual Deductible does not apply) |
| Diagnostic Breast Ultrasound after screening for the treatment of cancer | Plan Pays 100%<br>(Annual Deductible does not apply) |
| High tech radiology Services (including CT, PET, MRI, myelograms, and nuclear medicine scans) | Plan pays 80% after Annual Deductible |
| Physician/Professional charges | Plan pays 80% after Annual Deductible |
| Allergy treatment serum | Plan pays 100% |
| Allergy Injection visits | $25 Copayment per visit for primary care visit<br>$50 Copayment per visit for specialty care visit |
| **Preventive Visits and Services**<br>**NOTE: Cost Sharing will apply if non-preventive Services are provided during a scheduled preventive visit** | |
| Well-child care visits<br>(up to age 6) | Plan pays 100%<br>(Annual Deductible does not apply) |
| Annual Physical exams for children age 6 and above and adults<br>**Limited to one Primary or Specialty exam every 12 months** | Plan pays 100% for Primary Care visit<br>Plan pays 100% for Specialty Care visit<br>(Annual Deductible does not apply) |
| Annual well-woman exams<br>**Limited to one Primary or Specialty exam every 12 months** | Plan pays 100% for Primary Care visit<br>Plan pays 100% for Specialty Care visit<br>(Annual Deductible does not apply) |

| Covered Services | Health Plan Pays |
|---|---|
| Preventive care screening services and procedures (including pap smears, mammograms and prostate specific antigen (PSA) tests)<br>**NOTE: Cost Sharing will apply if non-preventive Services are provided during a scheduled preventive visit** | Plan Pays 100%<br>(Annual Deductible does not apply) |
| **Maternity Care** | |
| Routine prenatal visits and delivery (obstetrician, nurse midwife, OB nurse practitioner) and first postpartum visit | Plan pays 80% after Annual Deductible per visit |
| All other visits during pregnancy, (including genetics counselors and perinatologists) | $50 Copayment |
| Maternity Inpatient Services | Plan pays 80% after Annual Deductible per admission |
| Physician/Professional charges | Plan pays 80% after Annual Deductible |
| **OUTPATIENT SERVICES** | |
| Laboratory Services (When performed in an outpatient facility setting) | Plan pays 80% after Annual Deductible |
| X-rays and other routine radiology Services (When performed in an outpatient facility setting) | Plan pays 80% after Annual Deductible |
| Diagnostic Mammogram after screening for the treatment of cancer. | Plan Pays 100%<br>(Annual Deductible does not apply) |
| Diagnostic Breast Ultrasound after screening for the treatment of cancer. | Plan Pays 100%<br>(Annual Deductible does not apply) |
| High tech radiology Services (including CT, PET, MRI, myelograms, and nuclear medicine scans) | Plan pays 80% after Annual Deductible |
| Outpatient surgery (including professional charges) | Plan pays 80% after Annual Deductible |
| Outpatient facility/hospital charges (including professional charges) | Plan pays 80% after Annual Deductible |
| Chemotherapy and other visits to infusion centers | Plan pays 80% after Annual Deductible |
| Radiation therapy | Plan pays 80% after Annual Deductible |
| **Autism Spectrum Disorder Services** | |
| **Applied Behavioral Analysis**<br>Unlimited Visits | Plan pays 100%<br>Limited to Children up to age 21 |
| Physical therapy visits | $25 Copayment<br>Up to 60 visits per Plan Year, combined with occupational therapy<br>Unlimited visits for ABA services up to age 21 |
| Occupational therapy visits | $25 Copayment<br>Up to 60 visits per Plan Year, combined with physical therapy<br>Unlimited visits for ABA children up to age 21 |
| Speech therapy visits | $25 Copayment<br>Up to 25 visits per Plan Year<br>Unlimited visits for ABA children up to age 21 |
| **Habilitative and Rehabilitative Services: Physical, Occupational, and Speech Therapy, Multidisciplinary and Cardiac Rehabilitation** | |
| Physical therapy visits | $25 Copayment<br>Up to 60 visits per Plan Year, combined with occupational therapy<br>Unlimited visits for ABA services up to age 21 |

| Covered Services | Health Plan Pays |
|---|---|
| Occupational therapy visits | $25 Copayment<br>Up to 60 visits per Plan Year, combined with physical therapy<br>Unlimited visits for ABA children up to age 21 |
| Speech therapy visits | $25 Copayment<br>Up to 25 visits per Plan Year<br>Unlimited visits for ABA children up to age 21 |
| Multidisciplinary Rehabililation | Plan pays 80% after Annual Deductible |
| Cardiac Rehabilitation | $50 Copayment<br>Up to 36 visits per Plan Year |
| **Dialysis Care** | |
| Dialysis | $50 Copayment |
| **EMERGENCY SERVICES** | |
| Emergency department visits | $200 Copayment |
| Ambulance Services | Plan pays 80% after Annual Deductible per trip |
| **After Hours Urgent Care** | |
| After hours urgent care Services | $50 Copayment |
| **INPATIENT SERVICES** | |
| **Hospital Inpatient Care** | |
| Inpatient hospital (including medical detoxification) | Plan pays 80% after Annual Deductible per admission |
| Physician/Professional charges | Plan pays 80% after Annual Deductible |
| **MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER TREATMENT SERVICES** | |
| **Outpatient Mental Health** | |
| Outpatient individual therapy | $25 Copayment |
| Outpatient group therapy | $12 Copayment |
| Partial Hospital Services | Plan pays 100% |
| **Inpatient Mental Health** | |
| Inpatient mental health facility | Plan pays 80% after Annual Deductible |
| Physician/Professional charges | Plan pays 80% after Annual Deductible |
| **Outpatient Substance Abuse Disorder Treatment** | |
| Outpatient individual therapy (performed in a physician's office) | $25 Copayment |
| Outpatient individual therapy (performed in an outpatient facility/hospital) | Plan pays 80% after Annual Deductible |
| Outpatient group therapy | $12 Copayment |
| **Inpatient Substance Abuse Disorder Treatment** | |
| Inpatient treatment | Plan pays 80% after Annual Deductible |
| Physician/Professional charges | Plan pays 80% after Annual Deductible |
| **PHARMACY SERVICES** | |
| **Drugs and Supplies** | |
| Contraceptive drugs, intrauterine devices , oral transdermal,vaginal ring, and other devices | Plan pays 100%<br>(Annual Deductible does not apply) |
| Administered drugs for treatment of infertility | |
| **Outpatient Prescription Drugs** | |
| Up to the lesser of a 30 day supply or the standard prescription amount | |

| Covered Services | Health Plan Pays |
|---|---|
| Benefit Maximum per Plan Year<br>Applies to Out-of-Pocket Maximum, excluding Infertility drugs; Embedded | |
| Prescription Drug Deductible<br>Prescription drugs do not contribute toward the satisfaction of the Annual Deductible | |
| Copayments and Coinsurance for Outpatient Prescription Drugs count toward satisfaction of the Annual Cost Sharing Out-of-Pocket Maximums, if any. | |
| Preferred Generic Drugs | $10 Copayment at Kaiser Permanente Medical Center pharmacies and $20 Copayment at designated community pharmacies |
| Brand Name Preferred Drugs | $50 Copayment at Kaiser Permanente Medical Center pharmacies and $60 Copayment at designated community pharmacies |
| Non-Preferred Brand Drugs | $75 Copayment at Kaiser Permanente Medical Center pharmacies and $85 Copayment at designated community pharmacies |
| Specialty Drugs | $150 Copayment at Kaiser Permanente Medical Center pharmacies and at designated community pharmacies |
| Drugs for treatment of infertility<br>$30,000 Benefit Maximum per lifetime combined with all Infertility Treatment services and pharmacy services | Plan pays 50% |
| Drugs for treatment of sexual dysfunction disorders<br>Up to a 8 single dose supply each 30 days | 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)<br>Up to 100 days per Plan Year | Plan pays 80% after Annual Deductible |
| **Home Health Care** | |
| Covered Services<br>Up to120 visits per Plan Year | Plan pays 80% after Annual Deductible |
| **Hospice Care** | |
| Benefits for hospice care instead of traditional Services | Plan pays 80% after Annual Deductible |
| **Dental Services** | |
| Dental Services and appliances for accidental bodily injury to teeth | Plan pays 50% |
| 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 80% after Annual Deductible |
| **Prosthetics and Orthotics** | |
| Covered devices | Plan pays 80% after Annual Deductible |

| Covered Services | Health Plan Pays |
|---|---|
| **Pediatric Hearing Aids for Children to age 19** | |
| A hearing aid for each ear once every 48 months including fittings and follow-up care up to $3,000 per aid per ear.<br><br>One Medically Necessary replacement aid per ear every 48 months up to $3,000 per aid per ear. | Plan pays 80% after Annual Deductible |
| **Infertility Services** | |
| Diagnosis Services | $50 Copayment |
| Treatment Services (including related imaging, lab tests, procedures and professional Services) | Plan pays 50%<br>Up to a $30,000 Benefit Maximum per lifetime combined with other infertility services and infertility pharmacy services |
| In Vitro Services (IVF)<br><br>Up to $30,000 Benefit Lifetime Maximum combined with Infertility Treatment and Infertility pharmacy | Plan pays 50% |
| **Vision Services** | |
| Treatment for eye disease and accidental injury of the eye | $50 Copayment |
| **Optical eye exams for corrective lenses for Adults 19 and Older**<br><br>(Does not include fitting for cosmetic contact lenses)<br><br>**Limited to one exam every 12 months** | Plan pays 100% |
| **Optical eye exams for corrective lenses for Children to age 19**<br><br>(Does not include fitting for cosmetic contact lenses)<br><br>**Limited to one exam every 12 months** | Plan pays 100% |
| **Chiropractic Services** | |
| Up to 20 visits per Plan Year combined with Chiropractic and Spinal Manipulation Services | $25 Copayment for Chiropractic Services<br>$25 Copayment for Spinal Manipulation Services |
| **Acupuncture Services** | |
| Acupuncture Services<br><br>Up to 20 visits per Plan Year | $25 Copayment |