

Emory Health Care Plan
Summary Plan Description
Kaiser EPO HealthPlan
UPDATED EFFECTIVE 1-1-25



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Important Notice

The Kaiser Permanente Plan is established by Emory voluntarily and may be amended or terminated at any time by Emory, in its sole discretion. Amendments may, among other things, affect eligibility, contribution rates, benefits coverage, reimbursement rates, procedures, participation, etc., at any time, regardless of whether the individual is participating in the benefit plans at the time of amendment, and even after an individual retires. The Plan Administrator has the discretionary authority to interpret the provisions of the Plan and SPD, and its decisions are final and binding. Nothing in the SPD or the Plan gives or is intended to give any person the right to be retained in Emory's employment or to interfere with Emory's right to terminate the employment of any person.

Each health plan option under the Plan, including this Kaiser Permanente Plan, also has a Summary of Benefits and Coverage (SBC). The SBCs are based on templates required by the Affordable Care Act ("ACA") which are intended to standardize the description of medical options so individuals can easily compare medical options. While the SBCs are concise "snapshots" of the options, they are not intended to take the place of your Summary Plan Description (SPD) or the official plan document. Nothing in an SBC makes you eligible for a health plan option or any medical benefits unless the official plan document and SPD provide for such eligibility or benefits. Your eligibility and benefits will only be determined in accordance with and subject to the official plan documents and the applicable SPD.

Due to a federal law (ACA), you also will be able to purchase health coverage for yourself and your family members through the Health Insurance Marketplace (otherwise known as an Exchange). If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if your employer does not offer you coverage under a health plan that is "affordable" and provides "minimum value." Additional information about the coverage offered through the Marketplace and the tax credit that may be available to you is available in Emory's Marketplace notice which is available online. You may request a copy of this notice from Emory at any time, and one will be provided free of charge.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. The notice will describe how the Plan may use or disclose your health information and under what circumstances it may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Refer to the Plan's privacy notice for more information. You can obtain a copy of the notice by contacting the Emory University Benefits and Work Life Department at 404-727-7613.

Introduction

This is not an insured benefit plan. Plan benefits are self-insured by Emory University, which is responsible for their payment. Kaiser Permanente Insurance Company provides only administrative services on behalf of the Plan and does not insure the Plan benefits.

Emory University (the "Plan Sponsor") is pleased to sponsor a medical plan known as the Emory University Healthcare Plan (the "Plan").

The Plan covers and pays for the benefits described in this Summary Plan Description (SPD). Kaiser Permanente Insurance Company (KPIC) provides administrative Services for the Plan but is not an insurer of the Plan or financially liable for Plan benefits. The Plan Sponsor self-insures the Plan. The Plan Sponsor retains exclusive and ultimate responsibility for administration of the Plan.

This SPD describes the basic features of the Plan and contains only a summary of the key parts of the Plan and a brief description of your rights as a Participant. This SPD is not the complete official Plan document. If there is a conflict between the Plan document and this SPD, the Plan document will govern. A complete description of the Plan is on file at the office of the Plan Sponsor.

The Plan is an Exclusive Provider Organization (EPO) plan. Therefore, you must receive all Covered Services from Network Providers, except you can receive covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care from non-Network Providers as described in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non-Network Providers” section.

When you enroll in the Plan, your care will be provided in one of the following Kaiser Permanente Regions: Georgia. Each Region has its own Service Area, but you can receive Covered Services in any Region's Service Area.

Language Assistance

SPANISH (Español): Para obtener asistencia en Español, llame al 866-213-3062

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-213-3062

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 866-213-3062

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 866-213-3062

Plan reserves the right to amend, reduce, suspend or terminate any of the terms of the plan or coverage with a Notice of Material Modifications to enrollees not later than 60 days prior to the date on which such modification will become effective.

Schedule of Benefits

This section summarizes Cost Sharing and benefit limits such as day limits, visit limits and benefit maximums. It does not describe all the details of your benefits. To learn what is covered for each benefit (including exclusions and limitations); please refer to the identical heading in the “[Benefits and Cost Sharing](#)” section and to the “General Exclusions, General Limitations, Coordination of Benefits, and Reductions” section of this SPD.

Emory University Healthcare Plan		
Georgia EPO Benefit Summary		
Emory University / Emory Healthcare KP Use only: S0293	Emory Healthcare St. Joseph's KP Use only: S0294	
Effective Date: 1/1/2025-12/31/2025		
This is a summary of Benefits for your Kaiser Plan		
OVERALL PLAN FEATURES		
Plan Accumulation Type	Calendar Year	
Annual Out of Pocket Maximum		
Per Person	\$3,000	
Per Family	\$6,000	
Embedded - The out-of-pocket limit is the most you could pay in a year for covered Services. If you have other family members in this plan, they must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.		
Copays: One Copay per provider is charged per day.		
Visits: If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.		
ROUTINE PREVENTIVE EXAMS AND SERVICES		
Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings section are treated the same as non-preventive Lab and X-ray Services. See Preventive Services Listing, Screenings and Immunizations for a comprehensive list of Covered Services. Frequency and Age Limits managed by Network Provider except where noted.		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Wellness Exams – Adults (Including Well Woman)	\$0	No
Wellness Exams – Children	\$0	No
Preventive Screenings	\$0	No
Immunizations (Preventive) Adults and Children.	\$0	No
Health Education and Self-Management Classes	\$0	No
COVID-19		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Screening and Testing	\$0	Yes
Inpatient Treatment	Same as Medical Cost Share applies	Yes
Outpatient Treatment (includes adverse reaction treatment)	Same as Medical Cost Share applies	Yes
Telemedicine (any electronic medium)	\$0	Yes
Vaccine and administration (eligible participants)	Same as Medical Cost Share applies	Yes

OUTPATIENT SERVICES (Office or Outpatient Facility / Clinics, any Non-Inpatient setting)

Primary Care Cost Share will be charged for Family Practice, General Internal Medicine and General Pediatrics specialties. Specialty Care Cost Share will be charged for visits with all other medical specialties except Mental Health providers are Primary Care providers for the purposes of determining Participant Cost Share. **Note: Nurse Practitioner and Physician Assistant may be treated as primary or specialty based on their supervising physician status.**

Benefit Type	You Pay and/or Maximums	Applies to OOP
Office Visits Including House Calls Primacy Care Specialty Care	\$25 \$35	Yes Yes
Referred Hospital Clinic Visits Primary Care Specialty Care Facility Clinic Charges	\$25 \$35 \$150	Yes Yes Yes
Telemedicine Telephone, Video, or Chat/Online communications	\$0	Yes
Allergy Office visit Cost Share may apply Injection Testing Serum only	\$0 \$25 \$0	Yes Yes Yes
Biofeedback Services	\$25	Yes
Cardiac Rehab	\$25	Yes
Chemotherapy Services	\$35	Yes
Dialysis Services	\$25	Yes
Home Dialysis	\$25	Yes
Hearing Exam Audiometry exam	\$35	Yes
Infusion Services Requires skilled or medical administration. Office visit Cost Share may apply Infusion Home Infusion Infusion materials, drugs and supplies	\$35 \$0	Yes Yes
Injections and Immunizations Non-routine Office visit Cost Share may apply Injection	\$0	Yes
Travel Immunizations	Not covered	N/A
Male Sterilization Outpatient Surgery	\$150	Yes
Nutrition Visits	\$25	Yes
Radiation Therapy	\$35	Yes
Pulmonary Therapy	\$35	Yes
Respiratory Therapy	\$35	Yes
Retinal Photography	\$35	Yes
UV Light Treatment Medically Necessary Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if the equipment has been approved for you through the Plan's prior authorization process. UV Light Therapy (in the Office) Office Visit Cost Share may apply UV Light Therapy Box (for Home Use)	\$25 \$0	Yes Yes
Vision Exam Office Visit	\$0	Yes
Visit limits	One every 12 months	
NOTE: Medical care for eye illness or injury are covered under the Medical benefit by provider specialty		

HOSPITAL / SURGERY SERVICES

Benefit Type	You Pay and/or Maximums		Applies to OOP
	Emory University / Emory Healthcare	Emory Healthcare St. Joseph's	
Inpatient Hospital Includes room and board for private and semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Ancillary Services, and Supplies. Per admission			Yes
	\$250		
Ambulance Emergency Ground and Air and Water Ambulance Scheduled Ground and Air Ambulance Non-Network or Network Hospital to Network Hospital (repatriation)			Yes
	\$75		Yes
	\$75		Yes
	\$0		No
Emergency Services Accident and Illness. Copay waived if admitted			Yes
	\$250		N/A
	Yes		
Urgent and After Hours Care Urgent Care and After-Hours settings			Yes
	\$25		
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center.			Yes
	\$150		
Abortion* Elective Outpatient Surgery Inpatient Hospital per admission			Yes
	\$150	Not Covered	Yes
	\$250	Not Covered	Yes
Bariatric Surgery Outpatient Surgery Inpatient Hospital per admission			Yes
	\$150		Yes
	\$250		
Gender Affirming Surgery** Covered upper and lower body gender affirming surgeries. Outpatient Surgery Inpatient Hospital per admission			Yes
	\$150	Not Covered	Yes
	\$250	Not Covered	Yes
MATERNITY Includes most Routine Pre-Natal and Post-Partum care. Delivery charges, Non-routine Maternity Care and Routine Care not included under Preventive Care would be covered at the appropriate Cost Share.			
Benefit Type	You Pay and/or Maximums		Applies to OOP
Routine Pre-Natal and Post-Partum Care Pre-natal and post-partum visits			No
	\$0		
Hospital Inpatient Includes Contracted Birthing Center if available Per admission (facility) Includes Well baby facility fees when billed with mother Well Newborn			Yes
	\$250		Yes
	\$0		Yes
DIAGNOSTIC TESTS & PROCEDURES Includes Preventive Lab and X-ray screenings not specifically listed under Preventive Screenings: These Services are treated the same as Lab and X-ray Services in this section.			
Benefit Type	You Pay and/or Maximums		Applies to OOP
Diagnostic Lab & X-ray			Yes
	\$0		
High Tech/Advanced Radiology - CT, MRI, Nuclear Medicine, Myelograms and PET			Yes
	\$150		

FERTILITY SERVICES Services for Fertility include those related to or part of Artificial Insemination, Surgery, ZIFT, IVF and Fertility Drugs. Services to rule out the underlying medical causes of Infertility and Iatrogenic fertility preservation are part of the medical benefit. Fertility drugs see Pharmacy section

Benefit Type	You Pay and/or Maximums	Applies to OOP
Hospital Charges Per admission	\$250	Yes
Primary Care	\$25	Yes
Specialty Care	\$35	Yes
Diagnostic Lab & X-ray	\$0	Yes
Outpatient hospital or Ambulatory Surgery Center (ASC)	\$150	Yes
Artificial Insemination		
Primary Care	\$25	Yes
Specialty Care	\$35	Yes
Assisted Reproductive Technology (ART): IVF/ZIFT	\$150	Yes
Fertility Preservation for medical or Iatrogenic cryopreservation storage of eggs, and sperm retrieved.	\$0	Yes
Benefit Lifetime Maximum Combined for Fertility Services, Fertility Preservation, including up to 6 ovulations and insemination and Fertility Drugs	\$25,000	N/A

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

Benefit Type	You Pay and/or Maximums	Applies to OOP
Mental Health - Inpatient (Including Residential Treatment) Per admission	\$250	Yes
Partial Hospitalization Per admission	\$250	Yes
Mental Health - Intensive Outpatient , per day – Includes all Services provided during the day	\$25	Yes
Mental Health – Outpatient/Office Individual Visit Cost Share Group Visit Cost Share	\$25 \$12	Yes Yes
Substance Use Disorder Services - Inpatient (Including Residential treatment Services) Detox covered under medical benefits Per admission	\$250	Yes
Substance Use Disorder Services - Partial Hospitalization Per admission	\$250	Yes
Substance Use Disorder Services - Intensive Outpatient, per day Includes all Services provided during the day.	\$25	Yes
Substance Use Disorder Services – Outpatient/Office Individual Visit Cost Share Group Visit Cost Share	\$25 \$12	Yes Yes

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES Outpatient Cost Share for Rehabilitative and Habilitative therapies are applied as one Copay per provider per day. Visits are counted on a 'per visit' basis.

Benefit Type	You Pay and/or Maximums	Applies to OOP
Physical Therapy Visit maximum (Applies to Outpatient therapy)	\$25 90 visits per calendar year combined with OT and ST	Yes N/A
Occupational Therapy Visit maximum (Applies to Outpatient therapy)	\$25 90 visits per calendar year combined with PT and ST	Yes N/A
Speech Therapy Visit maximum (Applies to Outpatient therapy)	\$25 90 visits per calendar year combined with PT and OT	Yes N/A
Habilitation Therapy Physical/Occupational/Speech Therapy Age Limit Visit maximum (Applies to Outpatient Therapy)	\$25 None Unlimited	Yes N/A N/A

SKILLED CARE

Benefit Type	You Pay and/or Maximums	Applies to OOP
Home Health Care Per day Nurse visits (4 hrs.), Aide visits (4 hours), therapy visits and supplies associated with a visit. Visit maximum	\$25 120 days per calendar year	Yes N/A
Hospice Respite Care for Home Hospice Respite Care Maximum	\$0 \$0 Up to five consecutive days for each approved admission	Yes Yes N/A
Skilled Nursing Facility Per admission Day maximum	\$250 Unlimited	Yes N/A

OTHER Services

Benefit Type	You Pay and/or Maximums	Applies to OOP
Acupuncture Self referred Visit maximum	\$35 20 visits per calendar year	Yes N/A
Chiropractic Care Self referred Visit maximum	\$50 20 visits per calendar year	Yes N/A
Medical Coverage for Dental Services Care Preparation of the jaw for Radiation treatment, extraction of bony impacted wisdom teeth, anesthesia under certain circumstances. Outpatient Surgery Inpatient Hospital per admission	\$150 \$250	Yes Yes
Temporomandibular Joint Dysfunction Treatment Medical and surgical treatment of TMJ. Non-surgical dental treatment, including splints and appliances. Outpatient Surgery Inpatient Hospital per admission	\$150 \$250	Yes Yes
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury. Outpatient Surgery Inpatient Hospital per admission Time limit on benefit	\$150 \$250 1 year from date of injury	Yes Yes N/A

OTHER Services cont.		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Autism A diagnosis of ASD is required for benefits to apply Applied Behavioral Analysis Physical, Occupational and Speech Therapies Age Limit Visit Maximum	<p style="text-align: center;">\$25 \$25 None Unlimited</p>	<p style="text-align: center;">Yes Yes N/A N/A</p>
Durable Medical Equipment Including Diabetic testing supplies and equipment	\$0	No
Prosthetics and Orthotics Includes Medically Necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies.	\$0	No
Hearing Aids (dependent children up to age 26) Includes tests to determine appropriate model, fitting, counseling, adjustment, cleaning and inspection after warranty is exhausted Benefit Allowance Benefit Frequency	<p>\$0</p> <p>One device per ear Every 24 months</p>	<p>No</p> <p>N/A N/A</p>
Medical Foods Amino acid modified products	\$0	Yes
Vision Hardware - Frames and Eyeglass Lenses or Contact Lenses	Not Covered	N/A
Travel and Lodging For reasonable transportation and lodging that is primarily for and essential to receipt of a specific Covered Service where (1) the covered individual is unable to locate an In-Network provider in the State where the covered individual resides and (2) the covered individual must travel more than 50 miles to receive the Covered Service.		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Kaiser Permanente coordinated travel for Gender Affirming Surgery and Organ Transplants only Organ Transplants include recipient, care giver and donor Gender Affirming include patient and one care giver Transportation Limits Lodging Limits Daily Expense Limits Daily expenses include incidental expenses such as meals and does not include personal expenses. Benefit Maximum Benefit Lifetime Maximum	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"></div> <div style="width: 35%; background-color: #f0e68c; padding: 5px;"> Travel Not Covered for Gender Affirming Surgery </div> <div style="width: 30%;"></div> </div> <p style="text-align: center;">Unlimited Unlimited Reimbursement up to \$50 per day per person</p> <p style="text-align: center;">Unlimited Unlimited</p>	<p>N/A N/A N/A</p> <p>N/A N/A</p>
Member Reimbursed Travel and Lodging - For covered Services not offered within 100 miles of your residence. Includes patient and medically necessary companion. International travel is excluded. Transportation Limits Lodging Limits Daily expenses include incidental expenses such as meals and does not include personal expenses. Benefit Maximum Benefit Lifetime Maximum	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"></div> <div style="width: 35%; background-color: #f0e68c;"></div> <div style="width: 30%;"></div> </div> <p style="text-align: center;">Unlimited \$50 per night (\$100 per night if accompanied by a companion) Not covered Unlimited Unlimited</p>	<p>N/A N/A N/A</p> <p>N/A N/A</p>
Reimbursement for reasonable transportation and lodging expenses actually incurred by you and a companion in the course of obtaining the covered service. Services must be received at the at the most reasonable provider for the service provided.		

OUTPATIENT PRESCRIPTION DRUGS Obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified Note: Member will pay their copay or the full cost of the medication, whichever is less.

Benefit Type	You Pay and/or Maximums	Applies to Plan RX OOP
Retail		
Tier 1 - Preventive Tier Includes generic drugs for asthma, cholesterol, hypertension, diabetes, stroke, osteoporosis, antidepressants, anti-psychotics and anti-anxiety.	\$0 up to 30 days' supply \$0 31-60 days' supply \$0 61-90 days' supply	Yes
Tier 2 - Generic	\$10 up to 30 days' supply \$20 31-60 days' supply \$30 61-90 days' supply	Yes
Community pharmacy (first fill only)	\$10 up to 30 days' supply	Yes
Tier 3 – Brand	\$30 up to 30 days' supply \$60 31-60 days' supply \$90 61-90 days' supply	Yes
Community pharmacy (first fill only)	\$30 up to 30 days' supply	Yes
Tier 4 - Non-Formulary	\$60 up to 30 days' supply \$120 31-60 days' supply \$180 61-90 days' supply	Yes
Community pharmacy (first fill only)	\$60 up to 30 days' supply	Yes
Tier 5 - Specialty Tier	\$90 up to 30 days' supply \$180 31-60 days' supply \$270 61-90 days' supply	Yes
Note: Certain medications may be limited to 30-day supply.		
Mail Order		
Tier 1 - Preventive Tier Includes generic drugs for asthma, cholesterol, hypertension, diabetes, stroke, osteoporosis, antidepressants, anti-psychotics, and anti-anxiety.	\$0 up to 30 days' supply \$0 31-90 days' supply	Yes
Tier 2 – Generic	\$10 up to 30 days' supply \$25 31 to 90 days' supply	Yes
Tier 3 – Brand	\$30 up to 30 days' supply \$75 31 to 90 days' supply	Yes
Tier 4 - Non-Formulary	\$60 up to 30 days' supply \$150 31 to 90 days' supply	Yes
Note: Certain medications may be limited to 30-day supply. Not all medications are available via Mail Order.		
Blood Factors	\$0	Yes
Diabetic Coverage Some diabetic supplies may be covered under Durable Medical Equipment. Oral Medications and Insulin Diabetic testing supplies (meters, test strips) Diabetic administration devices (syringes)	=Generic/Brand Cost Share =Generic/Brand Cost Share =Generic/Brand Cost Share	Yes Yes Yes
Fertility Drug Coverage Fertility Preservation drugs	=Generic/Brand Cost Share =Generic/Brand Cost Share	Yes Yes
Growth Hormone	=Generic/Brand Cost Share	Yes
Sexual Dysfunction (Quantity limits apply)	=Generic/Brand Cost Share	Yes
Special Oral Foods Includes Amino Acid Modified Products	=Generic/Brand Cost Share	Yes
Supplemental Preventive Drugs Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis and stroke	=Generic/Brand Cost Share	Yes
Weight Loss	=Generic/Brand Cost Share	Yes

OUTPATIENT PRESCRIPTION DRUGS cont.

Benefit Type	You Pay and/or Maximums	Applies to Plan RX OOP
ACA Mandated Drugs*** (See Preventive Services for more information)		
Contraceptive Devices (diaphragms, cervical caps, etc.), methods and Contraceptive Drugs (FDA approved and prescribed by your doctor)	\$0	No
Emergency Contraception	\$0	No
Preventive Breast Cancer Drugs	\$0	No
Smoking Cessation	\$0	No
Statins (Cholesterol Lowering Agents)	\$0	No
PrEP for HIV Prevention	\$0	No
Preventive Over the Counter Products ****Preventive Over the Counter products are covered at a network pharmacy when prescribed by your provider for certain conditions. Aspirin Oral Fluoride Folic Acid Iron Supplements Female Contraceptives (spermicides, male and female condoms, emergency contraceptives and sponges) Bowel Prep	\$0 \$0	No No
* Voluntary abortions are excluded for the following groups: Emory/Saint Joseph's, Inc., Saint Joseph's Hospital of Atlanta, Inc., and The Medical Group of Saint Joseph's, LLC.		
** Gender Affirming Surgery Allowable Expenses are excluded for the following groups: Emory/Saint Joseph's, Inc., Saint Joseph's Hospital of Atlanta, Inc., and The Medical Group of Saint Joseph's, LLC.		
*** With prescription, no Cost Share. Without prescription, Participant pays retail cost.		
Refer to the Outpatient Prescription Drug section later in this document for coupon information.		
For items or Injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) Office visit Cost Share for administration may apply.		

Definitions

In this SPD, Participants and Dependents may be referred to as “You” or “Your.”

The following terms, when capitalized and used in any part of this SPD, mean:

Adverse Benefit Determination:

- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of your, or your beneficiary’s, eligibility to participate in the Plan.
- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and a failure of the Plan to cover an item or Service for which benefits are otherwise provided because such item or Service is determined to be experimental or investigational or not Medically Necessary or appropriate.
- The Plan’s determination of whether a participant or beneficiary is entitled to a reasonable alternative standard for reward under a wellness program.
- The Plan’s determination as to whether the Plan is complying with the non-quantitative treatment limitation parity provision of the Mental Health Parity and Addiction Equity Act.
- Plan determinations that involve plan compliance with surprise billing and cost-sharing protections under the Federal No Surprises Act.

Allowable Amount: The amount the provider has contracted to accept for Services rendered. This amount is based on a case rate for bundled professional and facility Services, a contract rate or a network fee schedule. In the case of pharmaceuticals, the Allowable Amount is an amount based on the average wholesale price plus a dispensing fee.

Allowance: A dollar amount the Plan will pay for benefits for a Service during a specified period. Amounts more than the Allowance, are your responsibility to pay and do not apply toward your Out-of-Pocket Maximum.

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 Network provider who can furnish such item or Service at such facility.

- Items or Services furnished because of unforeseen, urgent medical needs that arise at the time an item or Service is furnished, regardless of whether the Non-Network Provider satisfies the notice and consent requirements under federal law.

Claims Administrator: The KPIC self-funded claims administrator. You can find the Claims Administrator’s address in the “Customer Service Phone Numbers” section and on your Kaiser Permanente ID card.

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accord with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or because of, the discharge or transfer.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985.

Community Pharmacy: A retail pharmacy under contract with Kaiser Permanente.

Copayment: (aka Copay) A specified dollar amount that you must pay for certain Covered Services as described in the “Schedule of Benefits” section.

Cost Sharing/Share: Copayments.

Covered Service: Services that meet the requirements described in this SPD.

Custodial Care – Any Service, procedure or supply that is provided primarily:

- For ongoing maintenance of a person's condition, not for therapeutic value, in the treatment of an illness or injury
- To assist a person in meeting activities of daily living for example, assistance in walking, bathing, dressing, eating and preparation of special diets and supervision over self-administration of medication not requiring the constant attention of trained medical personnel

Such Services and supplies are regarded as Custodial Care without regard to the following:

- Who prescribes the Service and supplies
- Who recommends the Service and supplies
- Who performs the Service or the method in which such Services are performed

Dental Services: Items and Services provided in connection with the care, treatment, filling or removal, or replacement of teeth or structures directly supporting the teeth. (Structures supporting the teeth mean the periodontium,

which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.)

Dependent: A person who is enrolled in the Plan if the person's relationship to the Participant is the basis for eligibility. This SPD sometimes refers to a Dependent or Participant as "You."

Durable Medical Equipment (DME): Durable Medical Equipment (DME) is a device or instrument of a durable nature that meets all the following requirements:

- It can withstand repeated use;
- It is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of illness or injury; and
- It is appropriate for use in your home.

Eligible Charges Network Providers:

- For Services provided by Kaiser Permanente, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for Services provided to participants. Note the Eligible Charges may be greater than the billed amount.
- For Services that Network Providers (other than Kaiser Permanente) provide under a contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract. Note the Eligible Charges may be greater than the billed amount.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge you for the item if your benefits did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs and other items, the direct and indirect costs of providing Kaiser Permanente pharmacy Services, and the pharmacy program's contribution to the net revenue requirements of the relevant Kaiser Foundation Health Plan).
- For all other Services, the amounts that the Plan pays for the Services or, if the Plan subtracts Cost Sharing from its payment, the amount the Plan would have paid if it did not subtract Cost Sharing.

Eligible Charges Non-Network Providers:

- For Emergency Services and scheduled Services at a Network Hospital or ambulatory surgical center rendered by Non-Network Providers, the plan's Qualifying Payment Amount (QPA) – which is the median contracted rate (the middle amount in an ascending or descending list of contracted rates), adjusted for market consumer price index in urban areas (CPIU). The Cost Share will be based on the Recognized Amount (RA) which is lower of the QPA or the provider billed charges for a given Service. The QPA is based on contracted rates for the same or similar insurance market (individual, large group, small group, self-insured employer);

geography, based on MSAs (Metropolitan Statistical Area - a geographical region with a relatively high population density at its core and close economic ties throughout the area) and the non-MSA areas in a state; and Service provided in the same or similar specialty or type of facility. The contracted rates must reflect the total provider reimbursement amount contractually agreed, including cost-sharing, whether it's under a direct or indirect contract with the plan.

- To determine the QPA when there is no contracted rate KPIC will use the lower of an underlying fee schedule or the derived amount from Kaiser claims history.
- In the alternative KPIC may attempt to contract with the provider on a patient-by-patient basis.

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

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

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themselves or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

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

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act (EMTLA)) that is within the capability of the emergency department of a hospital or Independent freestanding emergency department, including professional, ancillary Services routinely available to the emergency department to evaluate the Emergency Medical Condition, Post Stabilization Services and outpatient observation during the same "visit" unless the provider/facility:
 - (1) determines you may travel using nonmedical or nonemergency medical transportation;
 - (2) has obtained informed consent from you for such items/Services (Consent by may not be obtained when Services are unforeseen

and urgent. Ancillary providers may never seek consent to bill the enrollee). In addition, if you (or your authorized representative) consent to the provision of Services by a non-Network Provider, then KPIC 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). The notice must include: (i) that the provider or facility is Non-Network with respect to the Plan; (ii) a good faith estimated amount that the provider or facility may charge including a notification that the provision of the estimate or the consent to be treated does not constitute a contract with respect to those estimated charges; (iii) a list of any Network providers at the facility who are able to furnish the items and Services involved and you may be referred, at your option, to that provider; and (iv) information about whether prior authorization or other care management limitations may be required in advance of receiving the items or Services at the facility.

- **Note:** Once your condition is Clinically Stable, covered Services that You receive are Post Stabilization Care and not Emergency Services EXCEPT when You receive Emergency Services from Non-Network Providers AND federal law requires coverage of Your Post-Stabilization Care as Emergency Services. Post-Stabilization Care is subject to all of the terms and conditions of this SPD including but not limited to Prior Authorization requirements unless federal law applies and defines such Post-Stabilization Care as Emergency Services.

EMTALA: The Emergency Medical Treatment and Labor Act (EMTALA) is a United States Congressional Act passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Exclusive Provider Organization (EPO): A health care plan design that requires the use of a specific network of health care providers for all but emergency and out-of-area urgent care Services.

Experimental and Investigational A Service is Experimental or Investigational if it meets one of the following criteria:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients);
- It requires government approval that has not been obtained when Service is to be provided;
- It cannot be legally performed or marketed in the United States without FDA approval;

- It is the subject of a current new drug or device application on file with the FDA;
- It has not been approved or granted by the U.S. Food and Drug Administration (FDA) excluding off-label use of FDA approved drugs and devices
- 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 items Services should be substantially confined to research settings or further research is necessary to determine the safety, toxicity or efficacy of the item or Service; or
- It is provided for Non-referred Services in connection with an approved clinical trial and/or Services in connection with a non-approved clinical trial;

Services related to clinical trials are considered Experimental or Investigational when;

- Items and Services are provided solely to satisfy data collection and analytical needs of a clinical trial and are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
- Items and Services customarily provided by the research sponsors free of charge for any enrollee in the trial; and
- Items or Services are needed for reasonable and necessary care arising from the provision of an Experimental or Investigational item or Service--in particular, for the diagnosis or treatment of complications.

Family: A Participant and all his or her Dependents.

Hearing Aid: An electronic device you wear for amplifying sound and assisting the physiologic process of hearing, including an ear mold if necessary.

HIPAA: Health Insurance Portability and Accountability Act, as amended.

Hospice: A specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts you may experience during the last phases of life due to a terminal illness. It also provides support to your primary caregiver and your family.

Kaiser Permanente: A Network of Providers that operates through eight Regions, each of which has a Service Area. For each Kaiser Permanente Region, Kaiser Permanente consists of Kaiser Foundation Hospitals (a California nonprofit corporation) and the Medical Group for that Region:

- Kaiser Foundation Health Plan, Inc., for the Northern California Region, the Southern California Region, and the Hawaii Region
- Kaiser Foundation Health Plan of Colorado for the Colorado Region
- Kaiser Foundation Health Plan of Georgia, Inc., for the Georgia Region
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., for the Mid-Atlantic States Region
- Kaiser Foundation Health Plan of the Northwest for the Northwest Region
- Kaiser Foundation Health Plan of Washington for the Washington Region

KPIC: Kaiser Permanente Insurance Company, which provides claims administrative Services for the Plan.

Material Modification: Per section 102 of the *Employee Retirement Income Security Act of 1974* (ERISA), a material modification includes:

- Any coverage modification that alone or combined with other changes made at the same time would be considered by “an average participant” to be “an important change in covered benefits or other terms of coverage under the plan or policy.”
- An enhancement of covered benefits, Services or other more general, plan or policy terms. For example, coverage of previously excluded benefits or reduced cost-sharing.
- A “material reduction in covered Services or benefits” or more strict requirements for “receipt of benefits,” including:
 - Changes or modifications that reduce or eliminate benefits
 - Increases in cost-sharing
 - Imposing a new referral requirement

Medically Necessary: A Service is Medically Necessary if, in the judgment of Kaiser Permanente on behalf of the Plan, it meets all the following requirements:

- It is required for the prevention, diagnosis, or treatment of your medical condition;
- Omission of the Service would adversely affect your condition.
- It is provided in the least costly medically appropriate setting; and
- It is in accord with generally accepted professional standards of practice that is consistent with a standard of care in the medical community.

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

Network Provider: A Network Hospital, Physician, Pharmacy, Skilled Nursing Facility, Medical Group, or any other health care provider under contract with Kaiser Permanente to provide Covered Services. Network Providers are subject to change at any time without notice. For current locations of Network facilities, please call Customer Service at the number listed in the “Customer Service Phone Numbers” section. To find a Kaiser Pharmacy visit www.kp.org - select the *Locate Our Services* tab, select your region, and then select the *Facilities* tab.

Network Facility: Any facility listed on www.kp.org. Note: Facilities are subject to change at any time. For the current locations, call Customer Service.

Network Hospital: A licensed hospital owned and operated by Kaiser Foundation Hospitals or another hospital which contracts with Kaiser Foundation Hospitals to provide Covered Services.

Network Optical Sales Office: An optical sales office owned and operated (or designated) by Kaiser Permanente. Please refer to www.kp.org for a list of Plan Optical Sales Offices in your area. Plan Optical Sales Offices are subject to change at any time without notice. For the current locations of Plan Optical Sales Offices, please go to www.kp.org or call the Customer Service phone number listed under “Customer Service Phone Numbers” in the Legal and Administrative Information section.

Network Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that Kaiser Permanente designates.

Network Physician: A licensed physician who is a partner, shareholder, or employee of the Medical Group, or another licensed physician who contracts with the Medical Group to provide Covered Services.

Network Ancillary Providers: Non-MD providers such as Psychologists, MFCCs, LCSWs, Optometrists, Physical, Speech, and Occupational Therapy. Such providers will be subject to the primary care Cost Share, however, verify referral requirements in the “How to Obtain Services” section.

Network Primary Care Provider: Family Practice, Internal Medicine, and Pediatrics. Note: Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based on the supervising physicians’ provider status.

Network Specialist: Medical Doctor with a specialty not considered primary care. Note: Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based on the supervising physicians’ provider status.

Medical Group: The following medical groups for the following Kaiser Permanente Regions:

- The Permanente Medical Group for the Northern California Region
- The Southern California Permanente Medical Group for the Southern California Region

- Colorado Permanente Medical Group, P.C., for the Colorado Region
- The Southeast Permanente Medical Group, Inc., for the Georgia Region
- Hawaii Permanente Medical Group, Inc., for the Hawaii Region
- Mid-Atlantic Permanente Medical Group, P.C., for the Mid-Atlantic States Region
- Northwest Permanente, P.C., Physicians & Surgeons, for the Northwest Region
- Washington Permanente Medical Group, P.C.

Network Skilled Nursing Facility: A licensed facility that provides inpatient skilled nursing care, rehabilitation Services, or other related health Services that contracts with Kaiser Permanente to provide Covered Services. The facility’s primary business is the provision of 24-hour-a-day skilled nursing care. The term “Skilled Nursing Facility” does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A “Skilled Nursing Facility” may also be a unit or section within another facility if it continues to meet the definition.

Non-Network Provider or Out-of-Network Provider: Any provider that is not a Network Provider.

Out-of-Pocket Maximum: The maximum dollar amount you can be required to pay for certain Covered Services you receive annually. This amount includes Cost Sharing amounts.

Participant: A person who is enrolled in the Plan if that person is eligible in his own right and not because of his or her relationship to someone else. This SPD sometimes refers to a Dependent or Participant as “You.”

Plan: The plan named in the “Legal and Administrative Information” section.

Plan Document: A comprehensive written instrument which sets forth the rights of the plan’s participants and beneficiaries. It sets forth what benefits are available, who is eligible, how benefits are funded, who is the named fiduciary, how the plan can be amended and the procedures for allocating plan responsibilities.

Plan Sponsor: The plan sponsor named in the “Legal and Administrative Information” section.

Plan Year: The date span (Plan begin and end dates) listed in the “Legal and Administrative Information” section.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your condition is Clinically Stable.

Primary Care: Care provided by a Network Provider who specializes in internal medicine, pediatrics or family practice Services.

Prior Authorization: Medical Necessity approval obtained in advance which is required for certain Services to be Covered Services under the Plan. Authorization is not a guarantee of payment and will not result in payment for Services that do not meet the conditions for payment by the Plan.

Prosthetics and Orthotics: An external prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Internally implanted prosthetic devices are devices placed inside the body through a surgical incision which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Orthotics are rigid or semi-rigid external devices that are used for the purpose of supporting a weak or deformed body part, improving the function of moveable parts or for restricting or eliminating motion in a diseased or injured part of the body.

Reconstructive Surgery: Surgery to improve function and under certain conditions, to restore normal appearance after significant disfigurement.

Region: A geographic area Serviced by Kaiser Permanente. See “Kaiser Permanente” in this “

Definitions” section.

Self-Funded Medical Plan: An arrangement in which the employer assumes the financial risk for providing health care benefits to enrolled employees and dependents. Instead of paying a fixed premium to an insurance carrier or HMO, the employer pays health care claims out of its own pocket as the claims are incurred. Claims are usually processed through a third-party administrator.

Service(s): Healthcare services, treatments, procedures, and items, including mental health care and behavioral health treatment to treat pervasive developmental disorders or autism.

Service Area: A smaller geographic area of a Kaiser Permanente Region.

SPD (Summary Plan Description): An ERISA required document which conveys the plan information in an understandable summary.

Specialty Care: Care provided by a Network Provider who provides Services other than Primary Care Services.

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

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

State of Emergency: During a national or regional state of emergency patient care may be handled in a variety of new and unusual locations (i.e., Drive up testing in parking lots, overflow inpatient care in convention centers, floating military hospitals and reopened previously closed facilities). Payment for Services rendered by licensed providers will be based on provider licensure rather than place of Service.

Surprise Billing: Unexpected billing by a Non-Network provider (except when you have consented) for 1) Emergency Services, 2) certain other Services performed by a Non-Network provider at a Network facility and 3) air ambulance Services from a Non-Network provider that is prohibited under federal law. When Surprise Billing occurs, you are only required to pay the Network cost-sharing amount. Your Cost-Sharing amount is calculated based upon the ‘Recognized Amount’ for a Non-Network provider/facility, and for Emergency Services and Ancillary Services, the Recognized Amount is the All Payer Model Agreement

amount, if applicable, or the amount calculated pursuant to a specified state law if applicable, or the Qualifying Payment Amount (QPA).

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Eligibility, Enrollment, and Effective Date

Plan eligibility requirements

You must meet the Plan's eligibility requirements listed below:

Service Area eligibility requirement

The Participant must live or work in a Kaiser Service Area at the time of enrollment. The Service Area cities are listed at the back of this SPD. You cannot enroll or continue enrollment as a Participant or Dependent if you cease to live within the cities listed.

Note: You may receive Urgent and Emergent care outside a Kaiser Service Area; see the Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non-Network Providers section for more information.

Additional eligibility requirements

Employees

Your eligibility date, if you are then in an Eligible Class, is the effective date of this Plan. Otherwise, it is the date you start working for Emory or, if later, the date you enter the eligible class. You are in an Eligible Class for coverage under this Plan if you are:

- A regular full-time or half-time (at least 20 hours per week) employee of Emory.
- A temporary full-time employee on an assignment at Emory University scheduled for at least six consecutive months.
- An Emory retiree who has returned to work at least half-time (at least 20 hours per week).

Individuals classified in Emory's sole discretion as part-time temporary employees or full-time temporary employees scheduled to work less than six consecutive months, are not in an Eligible Class and are not eligible to participate in the Plan.

Dependents

If you elect coverage, your dependents may also be eligible for coverage. Eligible dependents include:

Your Legal Spouse

Spouse includes your opposite sex or same sex spouse to whom you are legally married. This does not include registered domestic partnerships, civil unions or similar formal relationships recognized under state law.

Your Child

Child includes your natural or adopted child. Also, a child in the process of being adopted, stepchild or any child for whom you have legal custody.

A child is eligible:

- Up to age 26; or
- Regardless of age, if fully disabled and unmarried, provided he or she became fully disabled either:
- Prior to age 19; or
- Between the ages of 19 and 26, if that child was covered by the Plan when the disability occurred.

Your child is fully disabled if:

- He or she is not able to earn his or her own living because of mental or physical disability which started prior to the date he or she reached the maximum age for dependent children; and
- He or she depends chiefly on you for financial support and maintenance

Proof that your child is fully disabled must be submitted to Kaiser Permanente no later than 31 days after the date your child reaches the maximum age for eligibility (or within 31 days of your employment, if later). Coverage for a fully disabled child will cease on the first to occur of:

- Cessation of the disability;
- Failure to provide proof to the Plan Administrator that the disability continues;
- Failure to have any exam required by the Plan Administrator; or
- Termination of dependent child coverage for any reason other than reaching the maximum age for eligibility.

Emory will have the right to require proof of the continuation of the disability. Emory also has the right to have your child examined as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age for dependent coverage.

Your Surviving Spouse and/or Child(ren)

Emory University

The spouse may continue to participate in the medical plan at the active employee rate to age 65, if an employee dies and has at least 10 years of service and is at least 55 years old. If the employee was eligible to retire with medical benefits, the spouse may remain on the active employee plan until age 65 and then move to the Post-65 Retiree Health Reimbursement Arrangement (HRA)

Plan. Children may remain on the plan until age 26. Only eligible dependents covered prior to the employee's death may continue coverage.

If upon death, an employee does not meet the 10 years of service and 55 years of age eligibility criteria, the spouse and/or child(ren) may continue to participate in the medical plan under COBRA. Emory will subsidize the COBRA premium for six months.

Emory Healthcare

If an employee dies and at time of death met the grandfathered retiree benefits eligibility rules listed below, the covered spouse and child(ren) may enroll for the retiree Pre-65 POS Plan or Post-65 Retiree HRA Plan. If covered spouse is under age 65 at time of employee's death & enrolls for the Pre-65 POS Plan, then they would move to the Post-65 Retiree HRA Plan until his/her death. Children may remain on the plan until age 26 unless disabled (see eligibility for Children).

If upon death, an employee does not meet the grandfathered retiree benefits eligibility rules the spouse and/or child(ren) may continue to participate in the medical plan under COBRA.

Retiree Coverage

Retiree Medical Coverage for Emory University Employees

To be eligible for the grandfathered retiree medical plan, an employee must be employed at Emory University on the payroll, in a benefits eligible position prior to January 1, 2003. In addition, an employee (and covered dependents) must be covered by the Emory University Health Care Plan on the date of his/her retirement and satisfy the applicable age and service requirements.

Retiree Medical Eligibility Rules for Emory Healthcare Employees

To be eligible for the grandfathered retiree medical plan an employee (and covered dependents) must be enrolled at the time of retirement and meet the following criteria:

- Employed at Emory University Hospital or Emory University Hospital Midtown on the payroll in a benefits eligible position prior to December 21, 2002;
- Have been covered by the Emory Healthcare Medical plan at time of retirement;
- Minimum 55 years of age;
- 10 or more years of consecutive benefits eligible service;
- Meet "Rule of 75", defined as current age + years of service equals at least 75; and
- No breaks in benefits eligible service since December 21, 2002.

If a retiree-medical-eligible employee moves to a PRN, Registry or part-time position that is non-benefits-eligible, the employee will lose his/her eligibility for the EHC retiree medical plan.

Retiree Medical Coverage for Emory Clinic Staff

To be eligible for retiree medical coverage, you (and covered dependents) must be enrolled at the time of retirement and meet the following criteria:

- Employed at Emory Clinic on the payroll in a benefits-eligible position prior to July 1, 1983;
- Have been covered by the Emory Healthcare Medical plan at time of retirement;
- Minimum 55 years of age;
- 20 or more years of consecutive benefits-eligible service, or at least 60 years of age with 15 or more consecutive years of benefits-eligible service;
- Meet “Rule of 75,” defined as current age + years of service equals at least 75; and
- No breaks in benefits-eligible service since July 1, 1983.

If a retiree-medical-eligible employee moves to a PRN, Registry or part-time position that is non-benefits-eligible, the employee will lose his/her eligibility for the EHC retiree medical plan.

Retiree Medical Coverage for Grandfathered DeKalb Retiree

To be eligible for retiree medical coverage, you (and covered dependents) must be enrolled in the Emory Healthcare Medical Plan at the time of retirement and meet the following criteria:

- Employed by DeKalb Medical on the payroll in a benefits eligible position prior to January 1, 2003;
- Have been covered by a medical plan at time of retirement;
- Minimum 55 years of age AND minimum 10 years of service;
- Must be a participant in the Pension Plan;
- Age and credited years of service must equal 70; and
- May not have any breaks in benefits eligible service since January 1, 2003.

You will also be eligible if you retired from DeKalb Medical prior to September 9, 2018, and you were receiving retiree medical benefits from DeKalb Medical on September 8, 2018, and you have maintained retiree medical benefits as required by the terms of the plan.

Note: Wesley Woods Center, Emory Johns Creek Hospital, Emory Saint Joseph’s Hospital, and Emory Associates retirees are not eligible for retiree medical benefits.

Retiree and Covered Participants

Enrollees who are in an eligible retiree class and are age Pre-65 [including their child(ren) and/or Pre-65 spouses] will have a **one-time opportunity** to elect continuation of health coverage under the POS Health Care Plan. The retiree and/or spouse/surviving spouse of such retirees, may not add any new dependents. Only those dependents enrolled at the time of retirement are eligible for coverage under this or any Emory plan. If retiree medical coverage is waived, coverage cannot be elected at a later date.

At age 65, **eligible** retirees and/or spouses who elected to continue coverage under the POS Health Care Plan, will transition to the Emory Post-65 Retiree HRA Plan. Eligible child(ren) may remain covered under the POS Health Care Plan. See Retiree HRA Plan Document for more detailed information.

Important Note: No person may be covered both as an employee and dependent of another employee and no person may be covered as a dependent of more than one employee of Emory.

Enrolling Ineligible Individuals

It is your responsibility to report a change in a spouse's or dependent's eligibility. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded. If the wrong birth date of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Your and your dependents' Plan coverage may also be terminated or suspended for engaging in misrepresentation or fraud against the Plan, including filing or participating in filing a false misleading or fraudulent claim for benefits, allowing your ID card to be used by an individual who is not enrolled in the Plan, providing false or misleading information regarding a spouse or dependent, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria.

Emory reserves the right to audit at any time the status of your enrolled spouse and dependent children to determine if they meet the eligibility criteria. During an audit, you may be required to provide proof of eligibility. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be dis-enrolled from the Plan, possibly retroactively.

If Emory determines that misrepresentation has occurred, it may also terminate or suspend your coverage, require repayment of the ineligible individual's prior claims, require payment of the total value of the ineligible individual's coverage or take other corrective action.

If you or a dependent has been classified by Emory as ineligible and you or your dependent are reclassified into an eligible class, either by an action of the employer, Plan Administrator, or a governmental or judicial authority, you or your

dependent will be eligible to participate only prospectively following such reclassification, assuming all other eligibility requirements are met.

Enrollment Procedure

Enrolling is easy and available 24 hours a day via Employee Self-Service or e-Vantage through your employer's homepage. You must enroll within 31 days of your eligibility date. If you miss the enrollment period, you will not be able to enroll in the plan until the next annual enrollment period, unless you qualify under a Family Status Change or a Special Enrollment Period, as described below. Elections made during annual enrollment are effective the following January 1.

Newborns are automatically covered for 31 days after birth, if the mother is covered under the plan. To continue coverage after 31 days, you must enroll the child under the Family Status Change or Special Enrollment right provisions.

You and Emory share the cost of your health care coverage. By electing coverage under the Plan, you are also electing to have your contributions deducted from your pay on a pre-tax basis through the cafeteria plan. If the cost of coverage changes, your deductions will be automatically adjusted accordingly. Contributions depend on the coverage you choose. You will receive information on your contributions when you enroll via Employee Self Service or e-Vantage.

Annual Enrollment

Once you enroll for coverage under this Plan, the coverage will remain in effect unless you make a change during annual enrollment or you have a family status change or other special enrollment right, which would allow you to change your coverage as described below. Changes made during annual enrollment will be effective January 1 of the year following the enrollment.

Family Status Changes

A family status change is an event that may allow you to change your election for this Plan during the middle of the year. If one of the situations below applies, you may enroll or change your election within 31 days of the event. To be allowed, the event must affect eligibility for the type of coverage that you wish to change, and your election change must be consistent (under IRS rules) with the event that has occurred. If you do not enroll or make a change within 31 days of the event, you will not be able to enroll until the next annual enrollment period.

Family status changes include:

- Your marriage, divorce, or annulment;
- Birth of your child;
- Placement with you of a foster child or child for adoption;
- A change in the employment of your spouse or dependent, which affects his or her benefits eligibility, including termination or commencement of employment or a change in worksite;

- An event that would make a dependent child no longer eligible for coverage, such as his or her 26th birthday; or
- The death of your dependent.

Special Enrollment

If one of the situations below applies, you may enroll yourself and/or your eligible dependents within 31 days of the event. If you do not enroll within 31 days of the event, you will be not able to enroll until the next annual enrollment period. When you have a special enrollment right, if you are already enrolled and are adding a dependent, you may also change medical options at that time.

Loss of Other Health Care Coverage

You or your dependents may qualify for a special enrollment period if you did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time you or your dependents were covered under other creditable coverage. You may enroll within 31 days of losing other creditable coverage because of one of the following:

- Termination of the other plan;
- Loss of eligibility under the other plan (such as due to termination of employment);
- Death, divorce or legal separation;
- The contributions by another employer for the coverage terminated;
- COBRA coverage period ends (this does not include voluntarily dropping COBRA coverage before the maximum COBRA period ends); or
- For other reasons identified by the Department of Labor in its regulations relating to special enrollment rights.

If you or your dependent lost the other coverage because of a failure to pay the required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan), there is no special enrollment right.

Marriage or Acquisition of a New Dependent

Your marriage or your acquisition of a new dependent through birth, adoption or placement for adoption also triggers a special enrollment right, which allows you to enroll yourself, your spouse and your eligible dependents in the Plan within 31 days of that event. Election changes due to birth, adoption or placement for adoption are effective on the date of the birth, adoption or placement for adoption.

Medicaid and SCHIP

If you or your eligible dependent (1) becomes eligible for state-granted health premium assistance or (2) loses health coverage under Medicaid or the State

Children's Health Insurance Plan (known as SCHIP or CHIP), you will have a separate enrollment right. You can request coverage within 60 days of either of these two events (instead of the 31-day rule that applies for the other events).

Other Events Which May Entitle You to Mid-Year Changes

In addition to the family status changes and special enrollment rights mentioned above you may also have the right to change your coverage within 31 days of the event if one of the following events occurs:

- The employer sponsored cafeteria plan or benefit plan in which your spouse or dependent participates has a different period of coverage than this Plan and your spouse or dependent makes coverage changes under his or her plan based on that coverage period; in this case, you will be allowed to make changes under this Plan consistent with the election of your spouse or dependents effective when their new coverage election takes effect.
- There is a significant increase in the cost of coverage for the option you have selected, and you wish to switch to another option for the remainder of the year. Special rules (discussed in the Transfers between Entities section) apply to election changes when you transfer your employment between entities.

Making a Mid-Year Change

If you have a family status change, special enrollment right or another event that entitles you to make mid-year changes, you have 31 days from the date of the event to change your coverage (except for the special rule that applies for SCHIP, as explained above). Your changes must be consistent with your changes in family status or special enrollment right or another event and must be approved by the Plan Administrator. Permitted changes may include changing your coverage tier and, if the event is marriage, birth, adoption/placement for adoption or divorce, changing your medical plan option. You may also change your medical plan option if you are adding a dependent on account of a special enrollment event. As you decide what change is right for you, keep in mind that, even if you change your medical plan option, you are not allowed to change the type of health care spending account that you have (e.g., general purpose or limited purpose).

For example, if you are married and elect family coverage that covers your spouse and your only child, and your child turns 26 and no longer qualifies as a dependent, you may change your coverage to employee and spouse, but not to employee only or no coverage. You could also move from the Kaiser Permanente or POS Plan to the high deductible/HSA Plan, but you will not be able to move from a general-purpose health flexible spending account to a limited purpose health flexible spending account plan. This means that you will not be eligible to contribute to a health savings account until the following year (assuming you are eligible at that time).

For example, if you are married and elect family coverage that covers your spouse and your only child and you divorce, you may change your coverage to employee plus child, but not to employee-only or no coverage. You could also move from the high deductible/HSA Plan to the Kaiser Permanente or POS Plan, but you will not be able to move from a limited purpose health flexible spending account to a general purpose health flexible spending account plan until the beginning of the following plan year.

For additional information regarding making changes to your health flexible spending account election mid-year, you should refer to the summary plan description for the Emory University Beneflex Plan.

Transfers between Entities

Employees who transfer employment between companies (e.g., Emory University to Emory Healthcare, or vice versa) cannot change their election to participate in the Kaiser Permanente Plan, POS Health Plan or the HSA Health Plan on account of the transfer even if the cost of coverage increases or decreases. This means that if you transfer your employment you may not (1.) move from the Kaiser Permanente Plan or POS Health Plan to the HSA Health Plan (or vice versa), (2.) change your coverage tier (e.g., move from family to single), or (3.) enroll in the Kaiser Permanente Plan or POS Health Plan or HSA Health Plan if you declined to enroll previously.

Effective Date of Coverage

Employees

Your coverage will take effect on the later to occur of:

- Your date of hire (if you are eligible right away); or
- The date you became eligible (for example, if you worked fewer than 20 hours per week and transfer to a position in which you work at least 20 hours per week).

If you do not elect coverage within 31 days of your eligibility date, you will not be eligible to enroll in coverage until the next annual enrollment period unless you have a family status change or another event that entitles you to make a mid-year change.

Dependents

Coverage for your dependents will take effect on your eligibility date if you have properly enrolled each such dependent within 31 days from your eligibility event. You must report any new dependents, and provide the required information in a timely manner, for that dependent to be covered, even if it does not affect your required contributions for coverage. If you do not enroll dependents within 31 days of any dependent's eligibility date, you will not be able to enroll them until the next annual enrollment period unless there is a family status change or other event that entitles you to make a mid-year change.

Child Who Must Be Covered Due to a Qualified Medical Child Support Order (QMCSO)

Emory will extend group health benefits to an employee's non-custodial child(ren) as required by a qualified medical child support order. Dependent coverage will become effective as soon as administratively possible.

Important Note: As legally defined, upon receipt of a qualified order, Emory will enroll a non-custodial child(ren) and the employee (if not enrolled) without employee consent.

A QMCSO is an order or judgment from a court or administrative body that directs a health plan to cover a child of a participant under the plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedure for determining if the order is valid. Coverage under the Plan pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, you should contact the Plan Administrator.

Persons barred from enrolling

You cannot enroll if you have had your eligibility terminated for cause.

Participants with Medicare

If, during your enrollment in this Plan, you are or become eligible for Medicare (please see "Medicare" in the "

Definitions" section for the meaning of "eligible for" Medicare), your enrollment options are as follows:

- If federal law requires that the Plan is primary and Medicare coverage is secondary, your coverage under this Plan will be the same as it would be if you had not become eligible for Medicare.
- If you are or become eligible for Medicare and are in a class of beneficiaries for which the Plan is secondary to Medicare, contact the Plan Sponsor to determine your enrollment options.

Medicare late enrollment penalty

If you become eligible for Medicare Part B and do not enroll during the initial Medicare enrollment period, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. Also, if you go 63 days or longer without Medicare Part D coverage or creditable prescription drug coverage, you may have to pay a late enrollment penalty when you enroll in a Medicare Part D plan. Creditable prescription drug coverage means prescription drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage. If you are or become eligible for Medicare Part D, your Plan Sponsor is responsible for informing you about whether your drug coverage under this Plan is Medicare Part D creditable prescription drug coverage at the times required by CMS and upon your request.

How to Obtain Services

As a Participant or Dependent, you must receive all Covered Services from Network Providers inside the Service Area, except where specifically noted to the contrary in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section.

Kaiser Permanente gives you access to all of the Covered Services you may need, such as routine care with your own personal Network Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in the “Benefits and Cost Sharing” section.

Routine Care

Routine appointments are for medical needs that are not urgent, such as routine preventive care. Try to make your routine care appointments as far in advance as possible.

Urgent Care

You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the Urgent Care or advice nurse telephone number (see the “Customer Service Phone Numbers” section or www.kp.org). Note: Urgent Care received in a Kaiser Permanente Service Area from a Non-Network provider or emergency department is not covered.

For information about Urgent Care outside the Service Area, please refer to the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section.

Advice Nurses

Sometimes it's difficult to know what type of care you need. That's why Kaiser Permanente has telephone advice nurses available to assist you. These advice nurses can help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern, tell you what to do if a Network Provider is closed, or advise you about what to do next, including making a same-day appointment for you if it's medically appropriate. To reach an advice nurse, please call the advice nurse phone number listed in the “Customer Service Phone Numbers” section.

Your Personal Network Physician

Personal Network Physicians provide Primary Care and play an important role in coordinating care, including hospital stays and referrals to specialists. For the current list of physicians who are available as Personal Network Physicians, and to find out how to select a Personal Network Physician, please call Customer

Service at the number listed in the “Customer Service Phone Numbers” section. You can change your Personal Network Physician for any reason.

Telemedicine

Interactive visits between you and your Personal Network Physician using phone, interactive video, internet messaging applications, Click-to-Chat instant messaging and email are intended to make it more convenient for you to receive medically appropriate Covered Services. When available, you may receive Covered Telemedicine Services listed under the Benefits and Cost Sharing section, subject to the “General Limitations, Coordination of Benefits, and Reductions” section. You are not required to use Telemedicine Services.

<https://about.kaiserpermanente.org/our-story/our-care/is-telehealth-right-for-you>

Referrals

You are required to obtain a referral from your personal physician prior to receiving specialty care Services under the Plan. If you receive specialty care Services for which you did not obtain a referral, you will be responsible for all the charges associated with those Services.

A written or verbal recommendation by a Network Physician that you obtain non-covered Services (whether Medically Necessary or not) is not considered a referral and is not covered.

A referral is limited to a specific Service, treatment, series of treatments and period. All referral Services must be requested and approved in advance. You will receive a copy of the written referral when it is approved. The Plan will not pay for any care rendered or recommended by a non-Network Physician beyond the limits of the original referral unless the care is specifically authorized by your Network Physician and approved in advance.

Self-Referrals

You do not need a referral or Prior Authorization to receive care from any of the following:

- Your personal Network Physician
- Network Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, psychiatry, substance use disorders
- Obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology
- Network chiropractic and acupuncture Services

Although a referral or Prior Authorization is not required to receive care from these providers, the provider may have to get Prior Authorization for certain Services.

Additionally, some regions allow self-referral to certain specialties:

Georgia Region

- Dermatology
- Ophthalmology

Prior Authorizations

Certain Services require Prior Authorization for the Plan to cover them. Your Network Physician will request Prior Authorization when it is required, except that you must request Prior Authorization in order to receive covered Post-Stabilization Care from Non-Network Providers, as described in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section.

The provider to whom you are referred will receive a notice of Authorization by fax. You will receive a written notice of the Authorization in the mail. This notice will tell you the physician’s name, address and phone number. It will also tell you the time for which the referral is valid and the Services Authorized.

Required Prior-Authorization List

- All inpatient and outpatient facility Services (excluding emergencies)
- Office based habilitative / rehabilitative care: Occupational, Speech, and Physical therapies.
- All Services provided outside a KP facility
- All Services provided by non-network providers
- Drugs and Durable Medical Equipment not contained on the KP formulary

Note: for care received in a Kaiser Permanente facility or by Kaiser Permanente providers, authorization is managed by your physician and a component of your physician’s referral within the Kaiser system. For care received outside a Kaiser Permanente facility or by non-Kaiser Permanente providers, your physician will request Prior Authorization and or referral for care.

Second Opinions

Upon request and subject to payment of any applicable Cost Share, you may obtain a second opinion from:

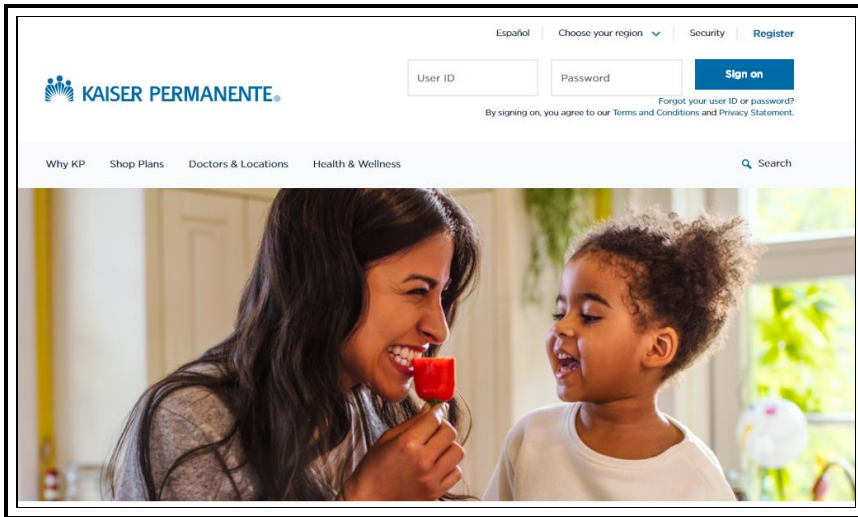
- A Network Physician about any proposed Covered Services or.
- A Non-Network Provider with Prior Authorization.

Your Identification Card

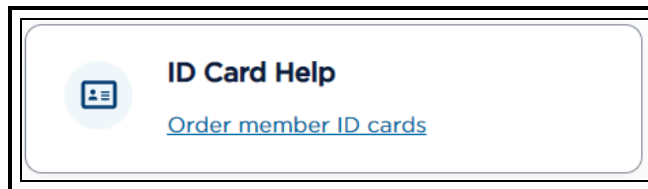
Your Kaiser Permanente identification card (ID card) has a medical or health record number on it, which you will need when you call for advice, make an appointment, or go to a provider for Covered Services. When you get care, please bring your Kaiser Permanente ID card and a photo ID. your medical or

health record number is used to identify your medical records and coverage information.

Your ID card is for identification only. For the Plan to cover Services, you must be a current Participant or Dependent on the date you receive the Services. Anyone who is not a Participant or Dependent will be billed for any Services they receive, and the amount billed may be different from the Eligible Charges for the Services.



To print a temporary card or replace your Kaiser Permanente ID card, log onto www.kp.org, then select the *Coverage and Costs* menu and the ID Card help option.

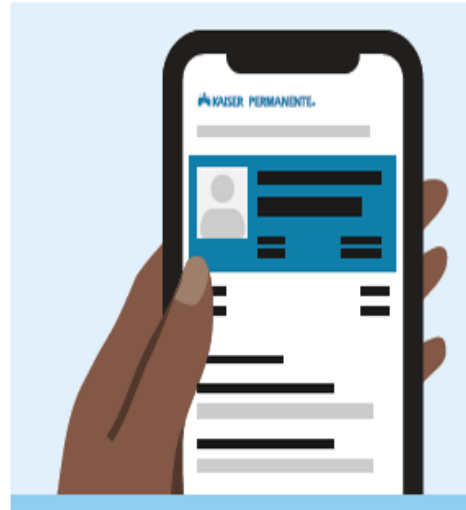


In line with federal requirements, your Kaiser Permanente ID card contains information about some of your benefits and costs, such as your deductible and out-of-pocket maximum.

In line with federal requirements, your Kaiser Permanente ID card contains information about some of your benefits and costs, such as your deductible and out-of-pocket maximum.

Download a Digital ID Card

1. If you haven't already done so, create your online account at www.kp.org/registernow. You can also create your online account in the Kaiser Permanente app.
2. Go to your app store and download the Kaiser Permanente app to your mobile device.
3. Sign into the app using your kp.org account information.
4. Once you sign into the app, look for the "Member ID Card" icon to see your updated ID card. You can show your digital ID card to check in for appointments, pick up prescriptions, and more.



Receiving Care in Other Kaiser Permanente Regions

You will probably receive most Covered Services in the Service Area of the Kaiser Permanente Region where you live or work. However, if you are in the Service Area of another Kaiser Permanente Region, you will also be able to receive Services from Network Providers in that Region. Referrals or Prior Authorization may differ among Regions. For information about Network Providers in other Kaiser Permanente Regions, please call Customer Service.

For 24/7 travel support Anytime, anywhere, call the Away from Home Travel Line at **951-268-3900** or visit www.kp.org/travel.

Moving Outside of the Service Area

If you move to an area not within a Kaiser Permanente Service Area you will be required to change your health plan to one that serves your area. Please contact your employer for instruction.

Getting Assistance

Kaiser Permanente wants you to be satisfied with the health care you receive. If you have any questions or concerns about the care you are receiving, please discuss them with your personal Network Physician or with any other Network Providers who are treating you. They want to help you with your questions. You may also call Customer Service at the number listed in the "Customer Service Phone Numbers" section.

Interpreter Services

If you need interpreter services when you call or when you get Covered Services, please let Kaiser Permanente know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you, at Network Facilities. For more information, please call Customer Service at the number listed in the “Customer Service Phone Numbers” section.

Network Facilities

At most Network Facilities, you can usually receive all the Covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Network Facility, and you are encouraged to use the Network Facility that will be most convenient for you:

- All Network Hospitals provide inpatient Services and are open 24 hours a day, seven days a week.
- Emergency Services are available from Network Hospital Emergency Departments (please refer to **www.kp.org** for Emergency Department locations in Your area).
- Same-day appointments are available at many locations (please refer to **www.kp.org** for Urgent Care locations in your area).
- Many Network Facilities have evening and weekend appointments.
- Many Network Facilities have a Customer Service department (refer to **www.kp.org** for locations in your area).
- Additionally, Kaiser Permanente care is available at certain Target Clinics in Southern California www.kptargetclinic.org

For current locations of Network facilities please visit www.kp.org or call Customer Service at the number listed in the “Customer Service Phone Numbers” section. To find a Kaiser Pharmacy visit www.kp.org - select *Pharmacy*.

Network Facilities for your area are listed in greater detail on www.kp.org, which details the types of Covered Services that are available from each Network Facility in your area because some Network Facilities provide only specific types of Covered Services. It explains how to make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice.

Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers

This section explains how to obtain covered emergency, post-stabilization, and out of area Urgent Care from non–Network Providers. The Non–Network Provider care discussed in this section is not covered unless it meets both following requirements:

- Emergency Services are covered if the Emergency Services would be covered if you received the care from a Network Provider. You do not need to get Prior Authorization from Kaiser Permanente to receive Emergency Services or Urgent Care outside the Service Area from non–Network Providers.
- Post Stabilization Care that are part of the same visit for Emergency Services is covered if authorized by Kaiser Permanente or until your attending emergency physician determines you are able to travel (using non-medical/non-emergency medical transportation), there is a Network facility within a “reasonable” distance considering your medical condition and you have access to/can pay for the non-medical transportation.

Emergency Services

If you have an Emergency Medical Condition (see definition in the “Definitions” section), call 911 (where available) or go to the nearest hospital emergency department, independent freestanding emergency department or Urgent Care clinic licensed to provide Emergency Services. You do not need Prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Network Providers or Non-Network Providers anywhere in the world, subject to the “General Exclusions, General Limitations, Coordination of Benefits, and Reductions” section.

For ease and continuity of care, you are encouraged to go to a Network Hospital emergency department if you are inside the Service Area, but only if it is reasonable to do so, considering your condition or symptoms. If you have been admitted to a Non-Network hospital, your stay will be covered if Kaiser Permanente is notified within 24hours or as soon as reasonably possible of stabilization of your condition.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your attending physician determines that your Emergency Medical Condition is Clinically Stable. Post-Stabilization Care also includes Medically Necessary Covered Durable Medical Equipment after discharged from a hospital and related to the same Emergency Medical Condition. For information on covered Durable Medical Equipment see [Durable Medical Equipment \(DME\), External Prosthetics and Orthotics](#). Post-

Stabilization Care received from a Non–Network Provider, including inpatient care at a non–Network Hospital, is covered until:

- Your attending emergency physician determines you are able to travel using non-medical/non-emergency medical transportation;
- There is an available Network facility within a “reasonable” distance considering your medical condition; you have access to/can pay for the non-medical transportation;

Note: You will be responsible for any Post Stabilization Services you consent to pay. For example, if your attending physician determines you are in a condition to provide voluntary consent; and

- The Non-Network provider/facility satisfies an enhanced notice and consent process whereby you accept liability for the Services;
- Your attending physician determinations are binding on the facility.
- Giving informed consent does not bind the Plan in any way to cover Post Stabilization Services; the provider should contact Kaiser Permanente in order to coordinate care.

To request Prior Authorization to receive Post-Stabilization Care from a Non–Network Provider, you (or someone on your behalf) must call Kaiser Permanente toll free at the telephone number on your Kaiser Permanente ID card before you receive the care if it is reasonably possible to do so (otherwise, call as soon as reasonably possible). A Kaiser Permanente representative will then discuss your condition with the Non–Network Provider. If Kaiser Permanente decides that you require Post-Stabilization Care and that this care would be covered if you received it from a Network Provider, they will authorize your care from the Non–Network Provider or arrange to have a Network Provider (or other designated provider) provide the care. If Kaiser Permanente decides to have a Network Hospital, Network Skilled Nursing Facility, or designated Non–Network Provider provide your care, they may authorize special transportation Services that are medically required to get you to the provider. If this occurs, then those special transportation Services will be covered, even if they would not be covered under “Ambulance Services” in the “Benefits and Cost Sharing” section if a Network Provider had provided them.

Be sure to ask the Non–Network Provider to tell you what care (including any transportation) Kaiser Permanente has authorized, because once your attending emergency physician determines you are able to travel using non-medical/non-emergency medical transportation and there is a Network facility within a reasonable distance considering your medical condition, Unauthorized Post-Stabilization Care or related transportation provided by Non–Network Providers is not covered.

Sometimes extraordinary circumstances can delay your ability to call Kaiser Permanente to request authorization for Post-Stabilization Care from a Non–Network Provider (for example, if you are unconscious, or if you are a young

child without a parent or guardian present). In these cases, you (or someone on your behalf) must call Kaiser Permanente as soon as reasonably possible.

Denials of Appeals of claims for Emergency Services and related Post Stabilization Services are subject to the External Appeal process located in the Claims and Appeals Section.

Urgent Care

Within the Service Area

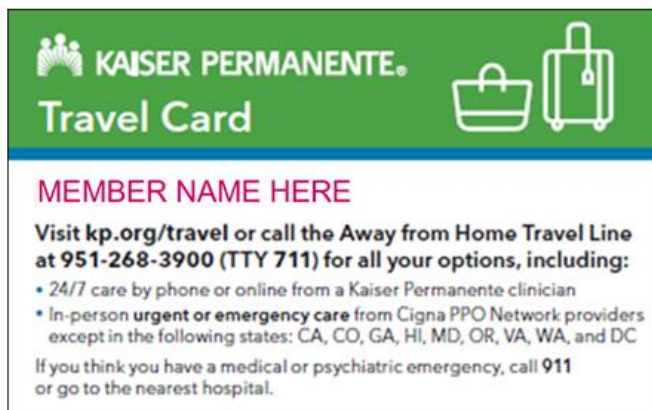
You may need urgent care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you are in the Service Area and think you may need urgent care, call the urgent care or advice nurse telephone number (see “Customer Service Phone Numbers” in the **Legal and Administrative Information** section or sign on to the **members www/kp.org** website).

The following Services are not covered under this section:

- Services that are not Emergency Services, Post-Stabilization Care, or Urgent Care that you receive outside the Service Area, even if those Services are related to your Emergency Medical Condition.
- Emergency Services, Post-Stabilization Care, and Urgent Care that you receive from Network Providers

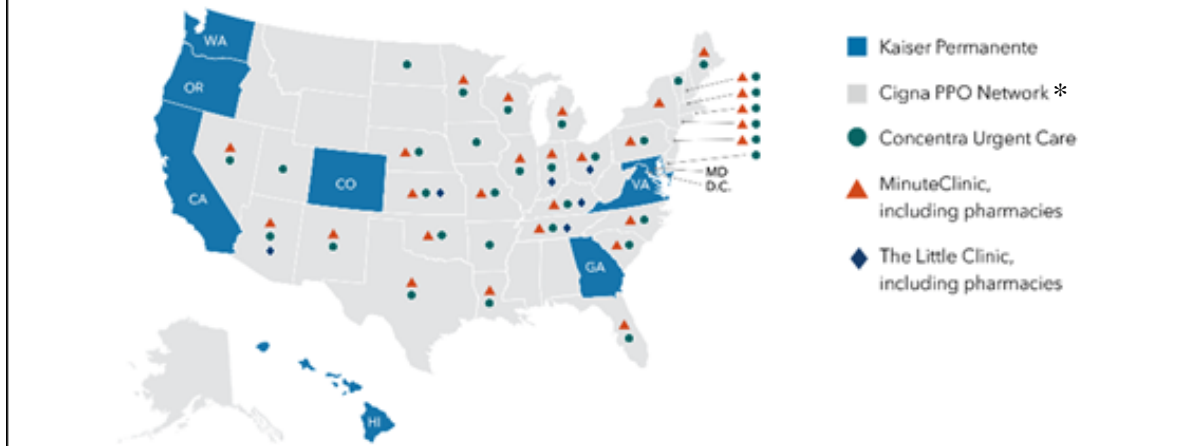
Important Note: Urgent Care received in a Kaiser Permanente Region from a Non-Network emergency department is not covered, except prior authorized Durable Medical Equipment related to Urgent care you received outside the Service Area.

Out-of-Area Urgent Care <http://kp.org/travel>



Access to care across the U.S.

Traveling employees have access to nonurgent, urgent, and emergency care throughout the U.S. Whether they are near or far, the care they need is always close at hand.



- For **Nonurgent** care you can always schedule in-person visits in states with Kaiser Permanente facilities or use kp.org or the Kaiser Permanente app across the U.S to get 24/7 care and advice from Kaiser Permanente clinicians by phone or online.
- You may also seek **Urgent** care at The Little Clinics (TLC) MinuteClinic®, Concentra, or any other urgent care facility outside a state where Kaiser Permanente operates. If you get care at MinuteClinic®, Cigna, TLC or Concentra outside a state where Kaiser Permanente operates, you'll be charged your standard copay or co-insurance.
- Note: Urgent Care received in Kaiser Permanente [Service Areas](#) from a Non-Network provider or emergency department is not covered.
- *Cigna PPO network is only available if your employer has opted in and is not available to members in WA and the NW

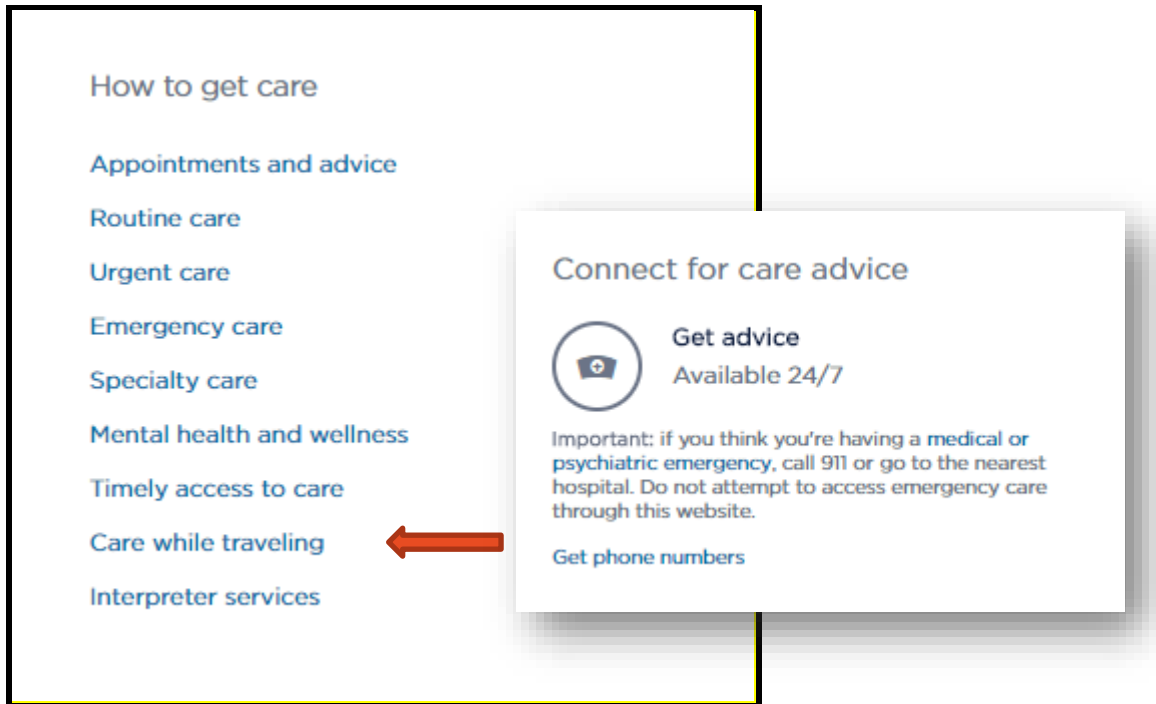
If you need prompt medical care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), your Plan covers Medically Necessary Services that you receive from a Non-Network Provider outside the Service Area to prevent serious deterioration of your (or your unborn child's) health if all the following are true:

- You receive the Services from Non-Network Providers while you are temporarily outside the Service Area;
- The care cannot be delayed until you return to our Service Area; and
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to the Service Area.

Follow-up care from a Non-Network urgent care provider is not covered, except prior authorized Durable Medical Equipment related to Urgent care you received outside the Service Area.

Note: Urgent Care received in Kaiser Permanente [Service Areas](#) from a Non-Network provider or emergency department is not covered.

Network Urgent Care is also available outside a state where Kaiser Permanente facilities are located (CA WA, OR GA, VA, MD & DC) from CVS Minute Clinics™. To check availability and location log onto www.kp.org or call the KP [Advice Nurses](#).



Services Not Covered Under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" Section

The following Services are not covered under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section (instead, refer to the "Benefits and Cost Sharing" section):

- Services that are not Emergency Services, Post-Stabilization Care, or Urgent Care that you receive outside the Service Area, even if those Services are related to your Emergency Medical Condition.
- Emergency Services, Post-Stabilization Care, and Urgent Care you receive from Network Providers.

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care outside the Service Area from a Non–Network Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. To request payment or reimbursement, you must file a claim as described in the "**Error! Reference source not found.**" section.

Cost Sharing

The Cost Sharing for Emergency Services, Post-Stabilization Care, and Urgent Care outside the Service Area that you receive from a Non–Network Provider is the Cost Sharing required for the same Services provided by a Network Provider as described in the "Schedule of Benefits" section. Your required Cost Sharing will be subtracted from any payment made to you or the Non–Network Provider.

- If you receive Emergency Services in the Emergency Department of a Non-Network Hospital you pay the Cost Share for an Emergency Department visit.
- If you were given Prior Authorization for inpatient Post-Stabilization Care in a Non-Network Hospital, you pay the Cost Share for hospital inpatient care.
- If you were given Prior Authorization for Durable Medical Equipment necessary for discharge from a Non-Network Hospital, you pay the Cost Share for Durable Medical Equipment.

Benefits and Cost Sharing

The only Services that are covered under this Plan are those that this “Benefits and Cost Sharing” section says that are covered, subject to exclusions and limitations described in this “Benefits and Cost Sharing” section and to all provisions in the “General Exclusions, General Limitations, Coordination of Benefits, and Reductions” section. Exclusions and limitations that apply only to a particular benefit are described in this “Benefits and Cost Sharing” section. Exclusions, limitations, coordination of benefits, and reductions that apply to all benefits are described in the “General Exclusions, General Limitations, Coordination of Benefits, and Reductions” section.

The Services described in this “Benefits and Cost Sharing” section are covered only if all the following conditions are satisfied:

- You are a Participant or Dependent on the date that you receive the Services;
- A Network Physician determines that the Services are Medically Necessary;
- The Services are provided, prescribed, authorized, or directed by a Network Physician except where specifically noted to the contrary in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section or the “How to Obtain Services” section; and
- You receive the Services from Network Providers inside the Service Area except where specifically noted to the contrary in the following sections for the following Services:
 - Authorized referrals as described under “Referrals” and “Self-Referrals” in the “How to Obtain Services” section;
 - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section;
 - Care received outside the Service Area as described in the “Receiving Care in Other Kaiser Permanente Regions” section; or
 - Emergency ambulance Service as described under “Ambulance Services” in this “Benefits and Cost Sharing” section.

Medical necessity

A Kaiser Permanente health professional will determine if Services are Medically Necessary for each member.

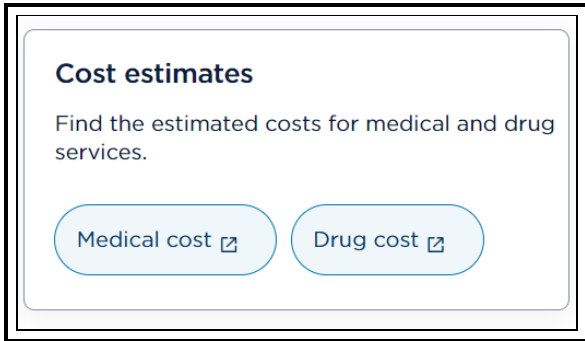
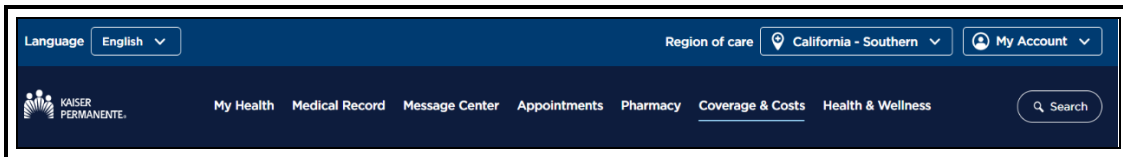
Cost Sharing (Copayments)

The “Schedule of Benefits” describes the Cost Sharing you must pay for Covered Services. Cost Sharing is due at the time you receive the Services, unless Network Providers agree to bill you. For items ordered in advance, you pay the Cost Sharing in effect on the order date (although the item will not be covered

unless you still have coverage for it on the date you receive it). Copayments are applied per provider per day.

Unless specified otherwise, when Services can be provided in different settings, the Cost Sharing is applied per the place of Service in which the care is delivered and according to the type of provider providing the Service. For example: if the Service is provided during a hospital admission, the Hospital Inpatient Services Cost Share is applied. If the same Service is performed in an office setting by a specialist, the specialty care office visit Cost Share is applied. If Services are provided in a hospital clinic setting, separate Cost Shares may apply to the hospital clinic charges and the physician charges; both hospital clinic and physician charges will be subject to applicable Cost Share.

To estimate your Cost Sharing and plan your medical expenses sign into www.kp.org then select *Coverage and costs*.



Then select *Medical or Drug Cost* to get an *estimate*. From this page, you will be taken to an external estimation tool and logged out of www.kp.org.

Benefit Maximums and Benefit limits

The “Schedule of Benefits” describes dollar limits, Benefit or Plan Maximums, Maximum Benefit Allowance and any visit or quantity limits applicable to certain Covered Services. If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.

Out-Of-Pocket Maximums

There are limits to the total amount of Cost Sharing you must pay annually for certain Covered Services that you receive in the same Plan Year. Those limits can be found in the “Schedule of Benefits.”

The out-of-pocket limit is the most you could pay in a year for covered Services. If you have other family members in this plan, they must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

After you reach the annual out-of-pocket maximum, you do not have to pay any more Cost Sharing for Service subject to the Plan Year out-of-pocket maximum through the end of the Plan Year. You will continue to pay Cost Sharing for Covered Services that do not apply to the Plan Year out-of-pocket maximum.

- The Services included in Out-of-Pocket Maximum are identified in the “Schedule of Benefits”.
- Note: If you are the only person on your plan, your plan will become a family plan **upon the addition of any eligible Dependent** to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days.

Outpatient Services

The following outpatient care is covered for Services to diagnose or treat an, injury or disease:

- Primary Care office visits including nutrition visits with Registered Dietitians (R.D.), State licensed nutritionists, and Certified Diabetic Educators (C.D.E)
- Specialty Care office visits, including consultation and second opinions
- Acupuncture
- Allergy Services
- Ambulance
- Bariatric surgery when you meet certain medical criteria
- Chemotherapy
- Chiropractic care
- Dental Services for Accidental Injury to Teeth, Dental Radiation, Dental Anesthesia, Organ Transplantation
- Diagnostic x-rays and lab tests, and other diagnostic tests such as EEGs EKGs performed during an office visit
- Dialysis Services
- Drugs that require administration or observation by medical personnel
- Durable Medical Equipment
- Habilitative and Rehabilitative Services
- Health Education
- Hearing Exam and Hearing Aids /Services
- House calls by a Network Physician when care can best be provided in your home

- Infusion Services provided in an outpatient setting
- Injections (except preventive immunizations)
- Medical supplies used during an outpatient visit
- Medically necessary surgical or non-surgical treatment of temporomandibular joint (TMJ) dysfunction - Dental treatment of TMJ dysfunction is not covered
- Maternity - prenatal and postnatal visits
- Outpatient surgery including FDA approved internally implanted Prosthetic devices such as breast implants following a covered mastectomy
- Physical, Occupational & Speech Therapies
- Preventive care Services (see “Preventive Care Services” in this Benefits and Cost Sharing” section for more details)
- Prosthetics and Orthotics
- Radiation therapy
- Respiratory therapy
- Surgical procedures performed in the office
- Ultraviolet light treatments
- Vision Refraction

Note: See “Preventive Exams and Services” for information on covered preventive Services.

Hospital Inpatient Services

The following inpatient Services are covered:

- Acute inpatient rehabilitation including physical, occupational, and speech therapy
- Anesthesia
- Bariatric surgery when you meet certain medical criteria
- Blood and blood products and their administration
- Diagnostic x-rays and lab tests, and other diagnostic tests such as EEGs EKGs and endoscopic procedures
- Dialysis
- Dressings and medical supplies used or applied during an inpatient hospital admission
- Drugs that require administration or observation by medical personnel
- Network Physician Services, including consultation and treatment by specialists
- General nursing care
- Medical social Services
- Medically necessary surgical or non-surgical treatment of TMJ. Dental treatment of TMJ dysfunction is not covered
- Maternity care and delivery (including cesarean section and newborn care)
- Operating and recovery room including FDA approved internally implanted Prosthetic devices such as pacemakers or artificial hips

- Respiratory therapy
- Room and board, including a private room, if Medically Necessary
- Specialized care and critical care units

Acupuncture Services

Acupuncture and Acupressure Services for pain relief and normalization of physiologic functions are covered. Services include passing long, thin needles through the skin to specific points and application of pressure at acupuncture sites.

To Locate a Network Provider Contact:

Georgia Region (no acupuncture network—utilize any willing provider)

Allergy Services

Specialty or Primary Cost Share is based on the rendering provider. Services include allergy testing, serum and injections.

Ambulance Services

Emergency

Emergency Services provided by ground or air licensed ambulance is covered when you have an Emergency Medical Condition. If provided through the 911 emergency response system, ambulance Services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital.

Scheduled

Non-emergency, scheduled ambulance trips are covered when a Network Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from Covered Services.

Any applicable Cost Sharing is waived when you are transferred from a Non-Network Facility to a Network facility for care.

The following destinations are covered when Medically Necessary:

- Home to hospital and return
- Home to skilled nursing facility
- Hospital to skilled nursing facility
- Skilled nursing facility to hospital
- Skilled nursing facility to home
- Home to doctor's office
- Hospital to hospital
- Skilled nursing facility to dialysis center and return

Exclusion:

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

Chiropractic Services

Chiropractic Services for the treatment of neuro musculoskeletal disorders are covered. Services include plain x-rays and adjunctive therapy associated with spinal, muscle or joint manipulation.

To Locate a Network Provider Contact:

Georgia Region Soteria Health Care
Call 770-455-8190 or email:
FindAGAProvider@SoteriaHealthcare.com

Exclusions:

The following Services are not covered:

- Chiropractic Services for conditions other than Neuromusculoskeletal Disorders
- Behavior training and sleep therapy
- Thermography
- Any radiologic exam, other than plain film studies, such as magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), bone scans and nuclear radiology
- Non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses; chiropractic appliances, supplies and devices
- Hospital Services, anesthesia, manipulation under anesthesia, and related Services
- Adjunctive therapy not associated with spinal, muscle, or joint manipulations, Vitamins, minerals, nutritional supplements, and similar products

Clinical Trials

In-Network and referred Non-Network Services for an Approved Clinical Trial are covered for Qualified Individuals to the extent Services identified in the "Schedule of Benefits" are covered outside an Approved Clinical Trial.

"Qualified Individual" means an enrollee who is eligible to participate in an Approved Clinical Trial per 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:

- The referring provider is a Network provider who has made this determination; or
- The patient provides medical and scientific information establishing this determination.

“Approved Clinical Trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition and that meets one of the following requirements:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) 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 through a system of peer review that the HHS Secretary determines meets all the following requirements:
 - i. It is comparable to the National Institutes of Health system of peer review of studies and investigations; and
 - ii. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application

Exclusions:

- Non-Approved Clinical Trials
- Investigational items or Services
- Items and Services that are provided solely for data collection and analysis and that are not used in the direct clinical management of the patient
- Services which are clearly inconsistent with widely accepted and established standards of care for the patient’s diagnosis

Dental Services

Accidental Injury to Teeth

Repair, but not replacement, of sound natural teeth, related to an accidental injury is covered. Services must be started as soon as medically appropriate and received within 12 months from the start of treatment. A “sound and natural tooth” is a tooth that (a) has not been restored previously, except if previously restored in an adequate manner with a filling crown or bridge and (b) has not been weakened by existing dental pathology such as decay or periodontal disease. Accidental injury does not include damage as a result of normal activities such as chewing or biting.

Dental Related Medical Care

Dental Services for radiation treatment

Dental evaluation, X-rays, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck are covered.

Dental Services pursuant to Transplants

Dental Services for potential transplant recipients who require pre-transplant dental evaluation and ‘clearance’ before being placed on the transplant wait list. Services include those necessary to ensure the oral cavity is clear of infection, such as evaluation, relevant x-rays, clearing, fluoride treatment, and extractions.

Dental anesthesia

For dental procedures, general anesthesia in a Network Hospital or ambulatory surgery center and the Services associated with the anesthesia are covered if any of the following are true:

- You are under age 7;
- You are developmentally disabled;
- You are not able to have dental care under local anesthesia due to a neurological or medically compromising condition; or
- You have sustained extensive facial or dental trauma.

Any other Service related to the dental procedure, such as the dentist's Services is not covered.

Exclusions:

- Dental coverage will not be provided for extractions, treatment of cavities, care of the gums or structures directly supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia (including braces), false teeth, or any other dental Services or supplies, except as listed above. Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane,

cementum of the teeth, and alveolar process. Exception Services required prior to placement on a transplant wait list.

- Dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders). This exclusion does not include medical Services to correct TMJ disorders.

Dialysis Care

The Plan covers dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

- 1) The Services are provided inside our Service Area;
- 2) You satisfy all medical criteria;
- 3) The facility is certified by Medicare and is a Network Facility; and
- 4) A Network Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, the Plan covers equipment, training and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Durable Medical Equipment (DME), External Prosthetics and Orthotics

DME must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered. A formulary is a list of DME, external prosthetics and orthotics covered by Kaiser Permanente. Examples of covered items include wheelchairs, hospital beds and oxygen. Medical supplies of an expendable nature, such as oxygen tubing, are covered if they are required for the effective use of the DME. Drugs purchased at the pharmacy for use in DME equipment are covered under the "Outpatient Prescription Drugs" benefit and not this benefit. To have coverage you must meet Kaiser Permanente's criteria for use of any equipment and obtain items from a Network Provider. Coverage is limited to the standard item of equipment that adequately meets your medical needs. Kaiser Permanente will decide whether to rent or purchase the covered equipment for your use. You will have to pay for non-covered equipment. Coverage includes fitting and adjustment. When the item continues to be Medically Necessary, coverage includes repair and replacement of the standard item in cases of loss, irreparable damage, wear or replacement required because of a change in your medical condition. You must return the equipment or pay the fair market price of the equipment when it is no longer covered.

The formulary guidelines allow you to obtain non-formulary DME (those not listed on the formulary for your condition) if they would otherwise be covered if KP criteria are met. To request a formulary exception contact Customer Service.

Internally implanted devices

Prosthetic and orthotic devices such as pacemakers, conventional intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, must be implanted during an approved surgery covered under another section of this "Benefits and Cost Sharing" section.

External Prosthetics

External Prosthetics must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered. Examples of external Prosthetic covered items include:

- Artificial arms and legs
- Ostomy and urological supplies
- Feeding tubes and enteral nutrition that is administered via a feeding tube
- Contact lenses following cataract surgery and glasses. Contacts when the intraocular lens is absent and cannot be replaced such as in aphakia or when all or part of the iris is missing as in aniridia

Orthotics

Orthotics must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered.

Services to determine the need for an external Prosthetic or an Orthotic and any subsequent fittings and adjustments are covered under the heading "Outpatient Services".

Exclusions:

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Comfort, convenience and luxury items and features
- Replacement of lost items
- Repair necessitated by misuse
- Exercise or hygiene equipment
- Shipping and handling, or restocking charges associated with obtaining DME, Prosthetics and Orthotics
- Spare or back up equipment
- Batteries or replacement batteries, except those specialized batteries used in covered DME equipment

Education and Training for Self-Management

Health education and training for self-management is covered when provided by a Network Physician or a qualified Network non-physician using a standardized curriculum to teach you how to self-manage your disease or condition.

Education and training may be provided in group or individual sessions. Where available, sample conditions include:

- Asthma
- Diabetes
- Coronary artery disease
- Obesity
- Weight management
- Pain management

Emergency Services

Emergency Services include professional, facility and ancillary Services such as laboratory, x-ray or imaging Services necessary to diagnose and Stabilize your condition in an Emergency Department. See the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section for more information. Any applicable Cost Shares for emergency Services are waived when you are directly admitted to the hospital from the Emergency Department.

Fertility Services

Inpatient and outpatient fertility Services include any necessary procedures, laboratory and radiology Services and drugs administered by medical personnel. Fertility Services include correcting underlying medical conditions causing infertility and artificial insemination. Additional eligible Services included advanced reproductive technologies such as in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT) and variations of these procedures (includes fertility preservation (Iatrogenic) Services of egg or ovarian tissue retrieval and short-term cryopreservation. Coverage for the storage will end when coverage ends or when the member reaches their lifetime maximum). Services to rule out the underlying medical causes of Infertility are part of the medical benefit.

Exclusions:

- Services to reverse voluntary, surgically induced fertility (for example, because of a vasectomy or tubal ligation)
- Any experimental, investigational, or unproven procedures or therapies
- Fertility Services when infertility is caused by or related to voluntary sterilization

Gender Affirming Surgery For Those Covered Under the Emory University / Emory Healthcare *

When authorized by Kaiser Permanente, your Plan covers the cost of authorized gender affirming surgery.

- **Below waist surgery:**

- **Assigned at birth male** –clitoroplasty, labiaplasty, penile skin inversion, vagina construction, bilateral orchiectomy, penile amputation, urethromeatoplasty, plastic repair of intoitus, vaginoplasty
- **Assigned at birth female** – hysterectomy, salpingo oophorectomy, colpectomy, phalloplasty, urethroplasty, scrotoplasty, plastic glans formation, Insertion of penile and testicular prosthesis
- **Above waist surgery:**
 - **Assigned at birth male** –Tracheal shave and facial hair removal, Medically Necessary breast augmentation if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment is not sufficient for comfort in the social role and Medically Necessary gender confirming facial reconstruction.
 - **Assigned at birth female** - Mastectomy with chest reconstruction and nipple/areola reconstruction
- Reasonable transportation and lodging expenses inside and outside of the Service Area when approved in advance by Kaiser Permanente. Includes transportation and lodging for the gender affirming patient plus one other person.
- Voice therapy lessons

Gender Affirming Surgery Limitations and Exclusions

- Reversal of genital surgery or surgery to revise secondary sex characteristics
- Above waist –
 - **(Assigned at birth male**, lipoplasty of the waist, face lifts, blepharoplasty, collagen injections, gender confirming facial reconstruction) or
 - **(Assigned at birth female** -liposuction and cosmetic chest reconstruction, pectoral implants);
- Blepharoplasty
- Rhinoplasty
- Voice modification surgery
- Abdominoplasty
- Below waist Surgery –
 - **Assigned at birth female** -liposuction to reduce fat in hips thighs and buttocks, calf implants).
 - **Assigned at birth male** - Electrolysis or laser hair removal, except for facial hair removal or when used to prepare the perineum for SRS (Sexual Reassignment Surgery) and pharmaceuticals such as Vaniqa);
- Cosmetic Surgery – Surgery or other Services that are intended primarily to change or maintain your appearance, voice, or other characteristics, except for the covered gender affirming surgery Services listed in this "Gender Affirming Surgery" section. (Male to Female -, Electrolysis or laser hair removal, except for facial hair removal or when used to prepare the perineum

for SRS (Sexual Reassignment Surgery) and pharmaceuticals such as Vaniqa) (Female to Male – cosmetic chest reconstruction);

- Unless covered under the Fertility Benefit, sperm procurement and storage in anticipation of future infertility, Gamete preservation and storage in anticipation of future infertility, Cryopreservation of fertilized embryos in anticipation of future infertility.
- Referrals outside US.
- Other surgeries which have no Medically Necessary role in gender identification and are considered cosmetic in nature

Related Services Covered in this Covered Services Section

- Outpatient hospital or ambulatory surgery center Services
- Outpatient prescription drugs
- Outpatient administered drugs
- Prosthetics and orthotics
- Psychological counseling
- Outpatient imaging and laboratory

*Gender Affirming Surgery Allowable Expenses are excluded for the following groups: Emory/Saint Joseph's, Inc., Saint Joseph's Hospital of Atlanta, Inc., The Medical Group of Saint Joseph's, LLC.

Hearing Aids

The following Services are covered up to the benefit maximum listed in the "Schedule of Benefits":

- Tests to determine the appropriate Hearing Aid model for you;
- Tests to determine the efficacy of the prescribed Hearing Aid;
- Visits for fitting, counseling, adjustment, cleaning and inspection after the warranty is exhausted; and
- One Hearing Aid per ear every 24 months.

You do not need to purchase aids for both ears at the same time. The maximum benefit amount for each Hearing Aid must be used at the initial point of sale. The 24-month period begins at the initial point of sale for each ear and is tracked separately for each ear. Two Hearing Aids are covered only when both are required to provide significant improvement that is not achievable with only one Hearing Aid as determined by a Network Provider.

Exclusions:

- Hearing Aids prescribed or ordered prior to enrollment or after termination of coverage

- Coverage for any Hearing Aid if payment has been made for an aid for the same ear in the previous 24 months
- Replacement parts for Hearing Aids
- Replacement of lost or broken Hearing Aids
- Replacement batteries
- Repair of Hearing Aids beyond the warranty
- Directly implanted Hearing Aids and associated surgery (see surgical implants under Durable Medical Equipment and Prosthetics)

Home Health Services

Skilled, part-time or intermittent home health Services are covered when you are confined to your home. Skilled home health Services are those Services provided by nurses, medical social workers, and physical, occupational and speech therapists. Medical supplies used during a covered home health visit are also covered. The Services are covered only if a Network Physician determines that you require skilled care, and it is feasible to maintain effective supervision and control of your care in your home. Home health aide Services are covered only when you are also getting covered home health care from one of the licensed providers mentioned previously.

Part-time or intermittent home health care visits are defined as follows:

- Up to two hours per visit for visits by a nurse and then each additional increment of two hours counts as a separate visit.
- Up to four hours per visit for visits by a home health aide is covered. Each additional increment of four hours counts as a separate visit.
- If billed by a Home Health Agency, a visit by other providers such as a medical social worker, or physical, occupational, or speech therapist counts as 1 visit and counts toward the applicable visit limits regardless of the number of hours present.

The following types of Services and supplies are covered only as described under these headings in this “Benefits and Cost Sharing” section:

- Durable Medical Equipment (DME), External Prosthetics and Orthotics
- Home Infusion Services
- Outpatient Laboratory, X-ray, Imaging and Other Special Diagnostic Procedures
- Outpatient Prescription Drugs

Exclusions:

- Custodial care - (For example: care an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training) This care is excluded even if the care would be covered if it were provided by a qualified medical professional in a hospital or a skilled nursing facility.

- Full time nursing care in the home
- Homemaker services and supplies, including meals delivered to your home
- Home health care a Network Physician determines may be more appropriately provided for you in a Network Facility, Network Hospital or a Network Skilled Nursing Facility

Home Infusion Services

Home infusion therapy is the administration of drugs in your home using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Home infusion includes intravenous delivery of parenteral nutrition when nutritional needs cannot be met by the oral or enteral route as determined by a Network Physician. The infusion therapy must be delivered by a licensed pharmacy. Home Services are also provided to ensure proper patient education and training and to monitor the care of the patient in the home. These Services may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. You do not need to be confined to your home to receive home infusion Services. The following are covered home infusion Services:

- Administration
- Professional pharmacy Services
- Care coordination
- All necessary supplies and equipment, including delivery and removal of supplies and equipment
- Drugs and Biologicals
- Nursing visits related to infusion

Hospice

If a Network Physician diagnoses you with a terminal illness and determines that your life expectancy is twelve (12) months or less, you may choose home-based hospice care instead of traditional Services that you would otherwise receive for your illness. If you choose hospice care, you are choosing to receive care to reduce or relieve pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may continue to receive Covered Services for conditions other than the terminal illness. You may change your decision to receive hospice care at any time.

The following Services and supplies are covered on a 24-hour basis:

- Network Physician and nursing care
- Counseling and bereavement Services
- Physical, occupational, speech or respiratory therapy for purposes of symptom control or to enable you to maintain activities of daily living.
- Medical social Services
- Home health aide and homemaker Services

- Covered Durable Medical Equipment and Medical supplies
- Palliative care prescription drugs, in accordance with Kaiser Permanente's drug formulary guidelines
- Short-term (no more than 5 days at a time) inpatient care, limited to respite care and care for pain control, and acute and chronic symptom management.
- Dietary counseling

Maternity Services

See the Preventive Services section for information on Prenatal Services covered at zero Cost Share.

The Plan covers physician charges for maternity care, delivery and postnatal care. Also covered are hospital Services (including network birthing centers) and newborn care.

Important Notes:

1) If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge.

2) Circumcision is covered for eligible newborns during the first 31 days of life regardless of Medical Necessity and thereafter only when Medically Necessary.

3) **Newborn child***. A Participant or Participant Spouse's newborn child is automatically covered under the Participant's membership for the first 31 days after birth. Well newborn (as defined by hospital billing), charges billed as part of the mother's bill will be attributed to the mother's Cost Share requirements. Separately billed well newborns may be subject to his/her own Cost Share, check the "Schedule of Benefits" section. Eligible sick newborns are subject to all Plan provisions including his/her own Cost Share requirements. If the parent of the newborn child is a Dependent child of the Participant, the newborn is **not** eligible for benefits unless enrolled as a dependent of the Participant.

4) During the first 31 –day period after birth, benefits for an eligible newborn child shall consist of Medically Necessary care for injury and sickness, including well childcare and treatment of medically diagnosed Congenital Defects and Birth Abnormalities. **Services provided during the first 31 days of coverage may be subject to the Cost Sharing requirements and any benefit maximums applicable to other sicknesses, diseases and conditions otherwise covered.** Note: If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days.

5) To continue the newborn's participation in the Plan beyond the 31-day period after the newborn child's birth, contact your employer. Your employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. For example: the newborn child is born on January 15; you have 31 days from the birth to notify the employer of the newborn's birth.

* Charges for well newborns (as defined by the hospital), billed as part of the mother's bill will be attributed to the mother's Cost Share requirements. Charges billed separately for Eligible sick and well newborns (as defined by the hospital) are subject to all Plan provisions including his/her own Cost Share requirements.

Medical Foods

Medical foods are foods that are prescribed by a Network Provider and used in the treatment of certain medical conditions, such as phenylketonuria (PKU) and other inherited diseases of amino acids and organic acids caused by genetic defects that can lead to life threatening abnormalities in body chemistry. Medical foods are not foods that are generally available in retail grocery stores. Medical foods are not used with feeding tubes. For coverage of nutritional formulas delivered via a feeding tube see the Durable Medical Equipment, External Prosthetics and Orthotics heading in this "Benefits and Cost Sharing" section.

Mental Health Services

Evaluation, crisis intervention, and treatment are covered for mental health conditions.

Inpatient

Inpatient psychiatric care (including residential treatment centers) is covered in a Network Hospital or licensed residential treatment facility. Coverage includes room and board, drugs, Services of Network Physicians, and Services of other Network Providers who are mental health professionals.

Outpatient Therapy

The following outpatient mental health care is covered:

- Partial Hospitalization, sometimes known as day-night treatment programs
- Intensive outpatient programs
- Individual and group visits for diagnostic evaluation and psychiatric treatment
- Other Services:
 - Psychological testing
 - Biofeedback and electroconvulsive therapy (ECT)
 - Visits for monitoring drug therapy

Outpatient Laboratory, X-ray, Imaging and Other Special Diagnostic Procedures

Outpatient laboratory, radiology, and diagnostic Services are covered when provided in an urgent care, free standing laboratory, radiology or imaging center, or Hospital outpatient department for the diagnosis of an illness or injury. Such Services include:

- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available
- X-rays and diagnostic imaging, including Magnetic resonance imaging (MRI), computed tomography (CT) and positron emission tomography (PET) and nuclear medicine exams
- Special procedures such as electrocardiograms and electroencephalograms are included in your office visit Cost Share

Outpatient laboratory, radiology, and diagnostic Services performed during an office visit are considered part of the office visit.

Note: See “Preventive Exams and Services” for information on covered preventive laboratory, x-ray, imaging and diagnostic procedures.

Outpatient Prescription Drugs

Outpatient drugs, supplies, and supplements are covered when **ALL** the requirements below (1-5) are met:

1. The item is **prescribed by a Network Provider** authorized to prescribe drugs **or** by one of the **following Non-Network Providers**:
 - **A dentist;**
 - **A Non-Network Provider** to whom you have been **referred by a Network Physician;**
 - **A Non-Network Provider** if you got the prescription in **conjunction with covered Out-of-Area Urgent Care or Emergency Services;**
 - **A Community Pharmacy in a Service Area outside of California;**
or
 - **The first refill of a prescription originally filled prior to enrollment in the Plan.**
2. The item is prescribed in accordance with **Kaiser Permanente drug formulary guidelines.**
3. Items provided to eligible newborns during the first 31 days of life and or prior to enrollment of a newborn, require prepayment and claims submission for reimbursement.
4. You get the item from a **Network Pharmacy** or the Kaiser Permanente mail order service, **except** that you can get the item from a **Non-Network Pharmacy if you obtain the prescription in conjunction with covered Urgent Care or Emergency Service outside the Service Area and it is**

not possible for you to get the item from a Network Pharmacy. Please refer to www.kp.org for the locations of Network Pharmacies in your area.

5. The item is one of the following:
 - Drugs that require a prescription by law including:
 - Contraceptive drugs including the emergency contraceptive pill and devices, such as diaphragms and cervical caps and over the counter contraceptives when prescribed by a Network physician;
 - Fertility drugs;
 - Drugs for the treatment of sexual dysfunction;
 - Smoking Cessation products; or
 - Drugs used in the treatment of weight control.
 - Drugs that don't require a prescription but are listed on Kaiser Permanente's drug formulary;
 - Diabetic supplies such as insulin, syringes, pen delivery devices, blood glucose monitors, test strips and tablets. Other diabetic supplies may be covered under Durable Medical Equipment; or
 - Specialty drugs – high cost drugs contained on the KP specialty drug list. To obtain a list of specialty drugs on the KP formulary, or to find out if a non-formulary drug is on the specialty drug list, please call Customer Service.

Kaiser Permanente uses a “formulary”. A “formulary” is a list of drugs that have been approved for coverage by the Pharmacy and Therapeutics Committee. The drug formulary guidelines allow you to obtain non-formulary prescription drugs (those not listed on the drug formulary for your condition) if they would otherwise be covered if the criteria for an exception are met. To request a formulary exception contact Customer Service. Prescriptions written by dentists are not eligible for non-formulary exceptions.

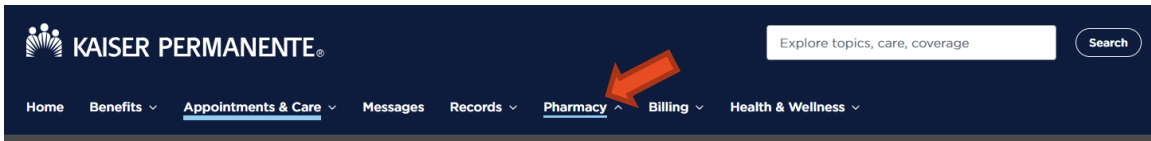
The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the formulary includes a pre-determined amount of an item that constitutes a Medically Necessary day's supply. The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (the Pharmacy can tell you if a drug you take is one of these drugs). Note: episodic drugs prescribed for the treatment of sexual dysfunction disorders may be limited by number of doses within a 30-day period.

Mail order service, subject to any Limitations and Copayments, is available. Not all drugs are available through the mail order service. Examples of drugs that cannot be mailed include:

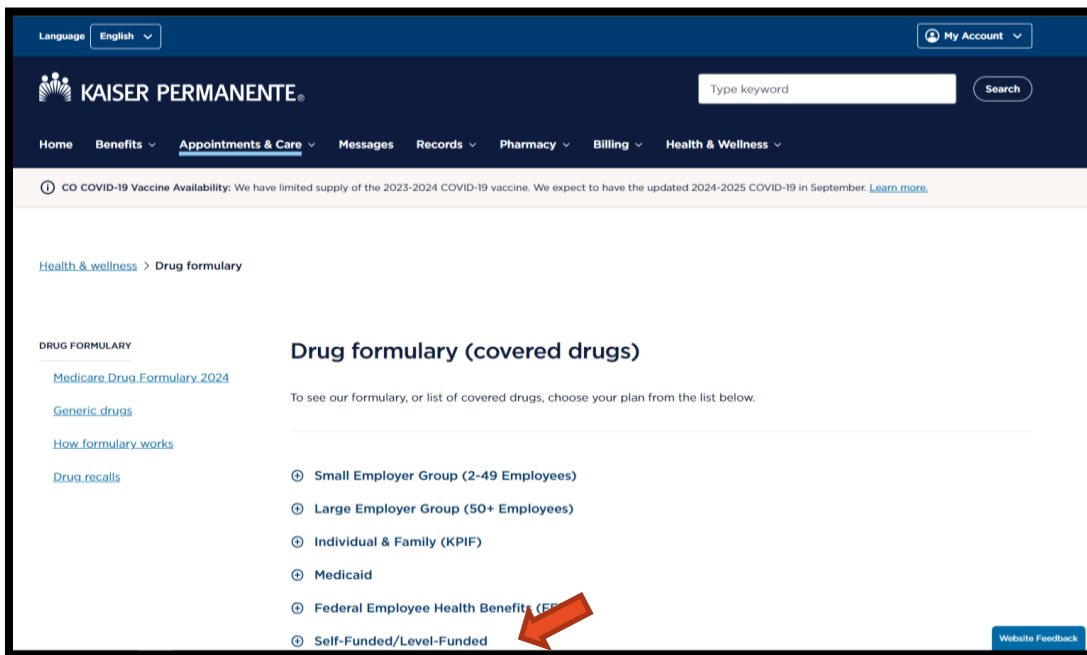
- Controlled substances as determined by state and/or federal regulations;
- Medications that require special handling; and
- Medications affected by temperature.

Refills may be ordered from Kaiser Pharmacies, the mail-order program, or online at www.kp.org. A Kaiser Pharmacy can provide more information about obtaining refills.

To locate a Network Pharmacy learn more about mail order or print a claim form, sign on to www.kp.org and click on “Pharmacy” or you may also call OptumRx at 1-866-427-7701.



To view the applicable formulary, search for the word “Formulary” on the www.kp.org website, then click on “Formulary (covered drugs),” and then click on “Self-Funded Formulary.” You can then choose an English language or Spanish language version of the formulary.



For outpatient prescription drugs and/or items covered under this Outpatient-Prescription Drug section and obtained at a pharmacy owned and operated by Kaiser Permanente, you may use certain manufacturer coupons you have procured, when allowed by law (i.e., on HSA plans you must satisfy your deductible prior using a coupon) and approved by Kaiser Permanente, as payment of Your Cost Sharing. You will owe any additional amount if the coupon does not cover the entire amount of Your Cost Sharing for Your prescription. If

the coupon is for an amount greater than the Cost Sharing amount you owe for your prescription, no credit, cash or other refund will be given for the excess amount. When a coupon is accepted toward satisfaction of Your Cost Sharing, an amount equal to the coupon value and, if applicable, any additional amount that you pay, will accumulate to Out-of-Pocket Maximum. Kaiser Permanente reserves the right to change the terms and conditions of its coupon program, including but not limited to the types and amounts of coupons that will be accepted at any time without prior notice. You may obtain information regarding the Kaiser Permanente coupon program at www.kp.org and search on the term “coupons”. Acceptance of Your coupon does not relieve You of Your responsibility regarding Cost Sharing if the drug manufacturer does not honor the coupon in whole or in part or if Kaiser Permanente later determines that the coupon was not allowed. www.kp.org/rxcoupons

Exclusions:

- If a Service is not covered under this Plan, any drugs or supplies needed relating to that Service are not covered
- Compounded products unless the drug is listed on the drug formulary or one of the ingredients requires a prescription by law
- Drugs used to enhance athletic performance
- Experimental or Investigational Drugs
- Drugs prescribed for cosmetic purposes
- Replacement of lost, damaged or stolen drugs
- Drugs that shorten the duration of the common cold
- Special packaging - Packaging of prescription medications is limited to Kaiser Permanente standard packaging
- Drugs which are available over the counter and prescriptions for which drug strength may be realized by the over-the-counter product. (Exception: those items listed in the Schedule of Benefits and the Preventive Exams and Services section below)
- Drugs or devices for which there is an over-the-counter equivalent

Preventive Exams and Services

Preventive care refers to measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care:

1. protects against disease such as in the use of immunizations;
2. promotes health, such as counseling on healthy lifestyles; and
3. detects disease in its earliest stages before noticeable symptoms develop such as screening for breast cancer.

The Preventive Services listed on www.kp.org search on the term “preventive care” are covered as required by the Patient Protection Affordable Care Act (PPACA) and are not subject to Deductibles, Copayments or Coinsurance.

Consult with your physician to determine what preventive Services are appropriate for you. Please note, state-specific preventive mandates, recommendations in effect for less than one year and contraceptive Services for Religious Employers or Eligible Organizations may not be applicable to your Plan. Preventive Services will be applied based on the member's medical status regardless of stated gender.

Preventive Services may change according to federal guidelines and your benefits will be updated to include these changes as they are made throughout the Plan year. You will be notified at least sixty (60) days in advance, if any item or Service is removed from the list of covered Services.

For a complete list of current United States Preventive Service Task Force (USPSTF) A&B recommended preventive Services required under the Patient Protection Affordable Care Act for which Cost Share does not apply, please call: the Customer Service number on the back of your ID card or visit: www.healthcare.gov/center/regulations/prevention.html.

State Specific Preventive Services covered by your Plan

- Medically necessary labs and X-rays associated with a well-child visit
- Ovarian cancer surveillance test for women over 35 or at risk

Exclusions for Preventive Care

- Personal and convenience supplies associated with lactation equipment such as pads, bottles, and carrier cases
- Upgrades of lactation equipment, unless determined to be Medically Necessary and prescribed by your physician
- Travel immunizations

Note: The following Services are not included under the Preventive Exams and Services benefit but may be Covered Services elsewhere in this SPD:

- Lab, Imaging and other ancillary Services associated with prenatal care not inclusive to routine prenatal care
- Non-routine prenatal care visits
- Non-preventive Services performed in conjunction with a sterilization
- Lab, Imaging and other ancillary Services associated with sterilizations
- Treatment for complications that arise after a sterilization procedure

Reconstructive Surgery

Coverage is provided for inpatient and outpatient reconstructive Services that:

- Will result in significant improvement in physical function for conditions because of injuries illness, congenital defects or Medically Necessary surgery or;
- Will correct significant disfigurement resulting from an injury, illness or congenital defects or Medically Necessary surgery;

- Following Medically Necessary removal of all or part of a breast, reconstruction of the breast as well as surgery and reconstruction of the other breast to produce a symmetrical appearance is covered; or
- Correction of congenital hemangioma (known as port wine stain) is limited to hemangiomas of the face and neck for children aged 18 years and younger.

Exclusions:

- Plastic surgery or other cosmetic Services and supplies intended primarily to change your appearance, including cosmetic surgery related to bariatric surgery

Rehabilitative and Habilitative Services (Including Early Intervention Services for Developmental Delays)

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible. Habilitative Services are therapeutic Services that are provided to children with congenital conditions (present from birth), and developmental delays to enhance the child’s ability to function and advance. Habilitative Services are like rehabilitative Services that are provided to adults or children who acquire a condition later in life. Rehabilitative Services are geared toward reacquiring a skill that has been lost or impaired, while habilitative Services are provided to help acquire a skill in the first place, such as walking or talking. Habilitative Services include, but are not limited to, physical therapy, occupational therapy and speech therapy for the treatment of a child with a congenital or genetic birth defect or developmental delays.

The following rehabilitative and Habilitative Services are covered as described in the “Benefits and Cost Sharing” section:

- Inpatient and Outpatient Multidisciplinary Rehabilitation in an approved organized multidisciplinary program or facility;
- Outpatient Physical, Occupational, and Speech Therapy (not billed by a Home Health Agency);
- Outpatient Cardiac Rehabilitation; or
- Outpatient Pulmonary Rehabilitation.

Exclusions:

- Maintenance therapy; or treatment when the Participant has no restorative potential;
- Treatment for congenital learning or neurological disability/disorder;
- Treatment for communication training, educational training or vocational training;

- Therapy primarily indicated for vocational training or re-training purposes, including sports physical therapy; or
- Speech therapy that is not Medically Necessary, such as:
 - Therapy for educational placement or other educational purposes;
 - Training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or
 - Therapy for tongue thrust in the absence of swallowing problems.
 - Physical therapy Services administered under the home health or hospice benefit, or in a hospital or skilled nursing facility. Passive modalities and/or treatment Services associated with physical therapy (e.g. electrical stimulation)

The Following Additional Habilitative Services are Covered

Treatment for Pervasive Developmental Disorders

Covered Services for pervasive developmental disorder or autism include:

- Medically Necessary Inpatient, Skilled Nursing Home and Outpatient care;
- Behavioral health treatment;
- Applied behavior analysis and evidence-based behavior intervention programs that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism.

Covered Services for pervasive developmental disorder or autism must meet all the following criteria:

- The treatment is referred by KPIC and administered by a Network Provider. Reminder certain Services require preauthorization:
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Network Qualified Autism Service Provider;
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate and the treatment plan includes:
 - the behavioral health impairments to be treated;
 - an intervention plan that includes the Service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the progress is evaluated and reported;
 - utilizes evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism; and

- discontinues intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for either of the following:
 - for purposes of providing (or for the reimbursement of) respite care, day care, or educational Services; or
 - to reimburse a parent for participating in the treatment program.

Note that Certain Services required Prior-Authorization;

- All inpatient and outpatient facility Services (excluding emergencies);
- Office based habilitative / rehabilitative care: ABA, Occupational; Speech, and Physical therapies;
- All Services provided outside a KP facility;
- All Services provided by non-network providers; and
- Drugs and Durable Medical Equipment not contained on the KP formulary.

Exclusions:

- Services not identified in an approved treatment plan;
- 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 skills for employment or vocational purposes;
- Professional growth courses; and
- Training for a specific job or employment counseling.

Skilled Nursing Facility Services

Skilled inpatient Services and supplies must be Services customarily provided by a Skilled Nursing Facility and must be above the level of custodial or intermediate care. The following Services and supplies are covered:

- Network Physician and nursing Services;
- Room and board;
- Medical social Services;
- Prescribed drugs;
- Respiratory therapy;
- Physical, occupational, and speech therapy;

- Medical equipment ordinarily furnished by the Skilled Nursing Facility;
- Medical supplies;
- Imaging and laboratory Services ordinarily provided by SNFs; and
- Blood, blood products and their administration.

Substance Use Disorder Services

Inpatient

Hospitalization (including Residential Treatment) is covered for medical management of withdrawal symptoms, including room and board, Network Physician Services, drugs that require administration or observation by medical personnel, dependency recovery Services, and counseling. Substance Use Disorder Rehabilitation Services in a licensed residential treatment Network Facility are also covered.

Outpatient

The following Services for treatment of Substance Use Disorders are covered:

- Partial hospitalization, sometimes known as day-night treatment programs;
- Intensive outpatient programs;
- Individual and group counseling visits; and
- Visits for medical treatment for withdrawal symptoms.

Transplant Services

Inpatient and outpatient Services for transplants of organs or tissues are covered – *for example*:

- Bone Marrow transplant/stem cell rescue
- Cornea
- Heart
- Heart & lung
- Liver
- Lung
- Kidney; Simultaneous kidney & pancreas
- Pancreas; Pancreas after kidney alone
- Small bowel; Small bowel & liver

The Services are covered if:

- KPIC has determined that you meet certain medical criteria for patients needing transplants; and
- KPIC provides a written referral to an approved transplant facility. The facility may be located outside the Service Area. Transplants are covered

only at a facility approved by KPIC, even if another facility within the Service Area could perform the transplant.

Covered Services include:

- Reasonable transportation and lodging expenses outside of the Service Area when approved in advance by Kaiser Permanente. Coverage will include the transplant recipient plus, one parent or guardian if the transplant recipient is a minor or one other person if the transplant recipient is an adult.
- Reasonable medical and hospital expenses of an organ/tissue donor which are directly related to a covered transplant are covered only if such expenses are incurred for Services within the United States or Canada. Coverage of expenses for these Services is subject to Living Donor Guidelines on www.kp.org.

Limitations and Exclusions:

- Kaiser Permanente does not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.
- Organ/tissue transplants which are experimental or investigational are not covered.

Member Reimbursed Travel and Lodging

A separate travel benefit per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with covered Service and care not included in other travel benefits. This applies when care is available either through an in-Network provider or at an out-of-network provider (when appropriate) more than 50 miles away from your residence.

To use the travel benefits you must pay travel and lodging expense upfront and submit a claim with travel and lodging receipts/expenses using www.kp.org (use the medical reimbursement claim form). Mileage reimbursement will be reimbursed at the current IRS limit.

Transportation

You can submit a claim for reimbursement amounts paid for transportation primarily for, and essential to, medical care:

- Bus, taxi, train, or plane fares or ambulance Service; and
- Transportation expenses of a parent who must go with a child who needs medical care;

Car expenses

- Out-of-pocket expenses, such as the cost of gas and oil, when you use a car to travel for medical reasons. If you don't want to use your actual expenses,

you will be reimbursed the IRS standard medical mileage rate based on the miles traveled.

- Parking fees and tolls, whether you use actual car expenses or the standard mileage rate.

Urgent Care Services

Urgent Care Services are sometimes referred to as afterhours care.

In the Service Area

Urgent Care Services are covered and may be provided in your doctor's office after office hours or a Network urgent care facility. If you think you may need urgent care, call the advice nurse telephone number for help. (See the "Customer Service Phone Numbers" section or www.kp.org)

Exclusion:

Except as noted below, Urgent Care Services from Non-Network Providers are not covered.

Outside of the Service Area

Urgent Care Services are also covered when you are temporarily away from the Service Area. Urgent Care Services are covered when they are Medically Necessary, and it is not reasonable given the circumstances to obtain the Service through Network Providers. See the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non-Network Providers" section for more information.

Vision Exams (routine)

Routine eye exams (eye refractions) provided by Network optometrists or ophthalmologists to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses are covered.

Exclusions:

- Corrective lenses, eyeglasses, frames, and contact lenses (including the fitting of contact lenses) except as notated in vision hardware, are not covered except that this exclusion does not apply to Services covered under "Durable Medical Equipment (DME), External Prosthetics and Orthotics" in the "Benefits and Cost Sharing" section
- All Services related to eye surgery for correcting refractive defects such as nearsightedness, farsightedness or astigmatism (for example, radial keratotomy and photo-refractive keratectomy)
- Orthoptic therapy, a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision
- Visual training
- Low vision aids and Services

General Exclusions, General Limitations, Coordination of Benefits, and Reductions

The Services listed in this section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered. Additional exclusions that apply only to a benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Abortion Elective - For Emory Healthcare St. Joseph's
Before coverage begins - Any Services, drugs, or supplies you receive while you are not enrolled in this Plan
Behavioral / conduct problems - Therapies and Services delivered in a non-clinical setting such as educational therapies and programs for behavioral/conduct problems.
Blood - The cost of whole red blood or red blood cells when they are donated or replaced and billed, except expenses for administration and processing of blood and blood products (except blood factors) covered as part of inpatient and outpatient Services.
Care by Non-Network Providers - Except for Authorized referrals, emergencies and out of area Urgent Care
Care in a half-way house.
Cosmetic Services - Except for Medically Necessary reconstructive surgery and related Services.
Custodial Care - 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. This exclusion does not apply to Services covered under "Hospice Care"
Dental Services - not listed elsewhere in your coverage. This exclusion does not apply to accidental injury to sound and natural teeth.
Education - Services other than self-management of a medical condition as determined by the Plan to be primarily educational in nature.
Excluded Providers - Services, supplies, equipment or prescriptions provided by OIG (Office of the Inspector General) excluded providers.
<p>Experimental and Investigational Services Kaiser Permanente, in consultation with Medical Group, determines that a Service is experimental and investigational when:</p> <ul style="list-style-type: none"> • Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients); • It requires government approval that has not been obtained when Service is to be provided; • It cannot be legally performed or marketed in the United States without FDA approval; • It is the subject of a current new drug or device application on file with the FDA; • It has not been approved or granted by the U.S. Food and Drug Administration (FDA) excluding off-label use of FDA approved drugs and devices • 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; • It is provided for Non-referred Services in connection to an approved clinical trial and/or Services in connection with a non-approved clinical trial;
<p>Services related to Clinical Trials are considered Experimental and Investigational when;</p> <ul style="list-style-type: none"> • Items and Services are provided solely to satisfy data collection and analytical needs of a clinical trial and are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); • Items and Services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

Items or Services needed for reasonable and necessary care arising from the provision of an investigational item or Service--in particular, for the diagnosis or treatment of complications.
<p>Fertility Services - The following services related to the further diagnosis and treatment of Infertility after initial diagnosis has been made:</p> <ul style="list-style-type: none"> - Reversal of male and female voluntary sterilization - Fertility Services when the infertility is caused by or related to voluntary sterilization - Any experimental, investigational or unproven fertility procedures or therapies. <p>This exclusion does not apply to Services to rule out the underlying medical causes of infertility.</p>
Foot Care - except when Medically Necessary.
<p>Gender Affirming related Services listed below: Emory University / Emory Healthcare</p> <p>Cosmetic Surgery Sperm procurement and storage in anticipation of future Fertility, unless covered under Fertility Services benefit Gamete preservation and storage in anticipation of future Fertility, unless covered under Fertility Services benefit Cryopreservation of fertilized embryos in anticipation of future Fertility, unless covered under Fertility Services benefit Other electrolysis or laser hair removal not specified as covered Vaniqua</p>
Gender Affirming Surgery – Emory Healthcare St. Joseph’s Employees only
Government Obligations - Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy for which the federal government has primary responsibility for payment. Also excluded are charges for Services directly related to military Service provided or available from the Veterans’ Administration or military medical facilities as required by law
Government programs - Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
Hearing Aid Services - Hearing Aids, hearing devices and related or routine examinations and Services
Hypnotherapy (Hypnosis)
Immunizations - administered strictly for the purpose of travel outside of the United States, with the exception of vaccinations associated with COVID-19
Illegal services -Treatments, procedures, equipment, drugs, devices, supplies or any other plan benefits, in each case, that are illegal under applicable law.
Licensed Physician - Charges for a Physician or other Provider acting outside the scope of his license.
Massage Therapy - except when provided as part of other covered Services
Medical supplies - Disposable supplies for home use, excluding urological and ostomy supplies.
Medicare Benefits - Your benefits are reduced by any benefits to which You are entitled under Medicare except for Members whose Medicare benefits are secondary by law.
Naturopathy Services - Naturopathy and related Services are limited to when a Network Provider makes a referral for Services in accord with Medical Group criteria
Network or Non-Network Provider (Close Relative) – Services rendered by a Network or Non-Network Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
Nutritional supplements - and formulas except for formula needed for the treatment of inborn errors of metabolism
Obesity - Fees or costs associated with weight reduction programs, fees and charges relating to fitness programs, weight loss or weight control programs, except for Network Diabetes prevention programs

<p>Outpatient Prescription Drugs Drugs prescribed for cosmetic purposes Drugs that shorten the duration of the common cold Drugs used to enhance athletic performance Drugs which are available over the counter and prescriptions for which drug strength may be realized by the over the counter product except where noted in your Schedule of Benefits Experimental or Investigational Drugs If a Service is not covered under this Plan, any drugs or supplies needed in connection with that Service are not covered Prescription drugs for which there is an over the counter drug equivalent except where noted in your Schedule of Benefits Replacement of lost, damaged or stolen drugs Special packaging; packaging of prescription medications is limited to Kaiser Permanente standard packaging</p>
<p>Personal Comfort Items for Home use - Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for you or your Dependent, i.e., exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench, air conditioners, air purifiers and filters, batteries and charges, dehumidifiers, humidifiers, air cleaners and dust collection devices.</p>
<p>Personal comfort items when Inpatient -Services and supplies not directly related to medical care, such as guest's meals and accommodations, hospital admission kit, barber Services, telephone charges, radio and television rentals, homemaker Services, over the counter convenience items and take-home supplies.</p>
<p>Private Duty Nursing - as a registered bed patient unless a Network Physician determines Medical Necessity</p>
<p>Private Duty Nursing in home or long-term facility</p>
<p>Private room unless Medically Necessary - or if a semi-private room is not available</p>
<p>Recreational, diversional and play activities</p>
<p>Religious, personal growth counseling - or marriage counseling including Services and treatment related to religious, personal growth counseling or marriage counseling, unless the primary patient has a mental health diagnosis</p>
<p>Services billed more than 365 days after the date of Service or dispensing.</p>
<p>Services, drugs, or supplies if not Medically Necessary</p>
<p>Services for conditions that a Network Physician determines are not responsive to therapeutic treatment.</p>
<p>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</p>
<p>Services related to a non-Covered Service - All Services, drugs, or supplies related to the non-Covered Service are excluded from coverage, except Services we would otherwise cover for the treatment of complications and rehabilitation of the non-Covered Service</p>
<p>Services that Are the Subject of a non-Network Provider's Notice and Consent Amounts owed to non-Network Providers when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable federal law.</p>
<p>Shoes - Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).</p>
<p>Surrogacy - Services related to conception, pregnancy or delivery in connection with a surrogate arrangement. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.</p>
<p>Testing for ability, aptitude, intelligence or interest</p>
<p>Third Generation Dependents - Services related to third generation dependents, unless enrolled covered as a dependent, (includes temporary enrollment under the plan for a limited number of days after birth).</p>
<p>Third Party Requests - Services, reports and/or examinations in connection with employment, participation in employee programs, insurance, disability, licensing, immigration applications, or on court order or for parole or probation.</p>
<p>Travel or transportation expenses - Travel or transportation expenses even though prescribed by a Network Physician or non-Network Physician except as noted as covered in the Summary of Benefits.</p>
<p>Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field</p>

Vision - low vision aids, eyeglasses, contact lenses and follow-up care thereof. Exception the purchase of eyeglasses, lenses, frames or contact lenses that follows cataract surgery (first pair only) or loss of lens due to eye disease for aphakia or aniridia and keratoconus.
Vision - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
Vision (Surgical Correction) - Radial keratotomy; and surgery, Services, evaluations or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem
Vision - Hardware (eyeglasses, lenses, contact lenses) as prescribed to correct visual acuity
Waived fees - Free Services (no charge items)
Wigs and toupees
Workers' Compensation - Services for any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. Exception: Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if covered by the Plan. Services or supplies for injuries or diseases related to you or your Dependent's job to the extent you or your Dependent is required to be covered by a workers' compensation law.

General Limitations

Network Providers will try to provide or arrange for the provision of Covered Services in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Network Provider's facility, complete or partial destruction of facilities, or labor disputes. Neither the Plan, KPIC, nor any Network Providers shall have any liability for delaying or failing to provide Services in the event of this type of unusual circumstance.

Coordination of Benefits

This "Coordination of Benefits" (COB) section describes how payment of claims for Services under the Plan will be coordinated with those of any other plan under which you are entitled to have claims for Services paid.

When Coordination of Benefits Applies

This "Coordination of Benefits" section applies when a Participant or a Dependent has health care coverage under more than one benefit plan under which claims for Services are to be paid.

The order of benefit determination rules described in this "Coordination of Benefits" section govern the order in which each Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan, the one that must pay first, pays in accordance with its terms without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the payments it makes so that payments from all plans do not exceed 100% of the total Allowable Expenses. [In the case of a plan with a Non-Duplication provision, the Secondary Coverage Plan will reduce the payment it makes so that all payments from all plans do not exceed what it Plan would have paid had it been the Primary Coverage plan.]

Definitions

For purposes of this "Coordination of Benefits" section only, terms are defined as follows:

"Coverage Plan" is any of the following that provides payment or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

- Coverage Plan includes: group and non-group insurance, health maintenance organization (HMO) contracts, closed panel or other forms of group or group type coverage (whether insured or uninsured); medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
- Coverage Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited health benefit coverage, as defined by state law; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

"This Coverage Plan" means the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Coverage Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

"Primary Coverage Plan" or **"Secondary Coverage Plan."** Order of benefit determination rules determine whether This Coverage Plan is a Primary Coverage Plan or Secondary Coverage Plan when compared to another Coverage Plan covering the person. When This Coverage Plan is primary, it determines payment of claims for Services first before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When This Coverage Plan is secondary, it determines payment of claims for Services after those of another Coverage Plan and may reduce its payments so that all payments and benefits of all Coverage Plans do not exceed 100% of the total Allowable Expense.

"Allowable Expense" means a health care expense, including Cost Sharing, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of Services (for example an HMO), the

reasonable cash value of each Service will be considered an Allowable Expense and a benefit paid. An expense or an expense for a Service that is not covered by any of the Coverage Plans is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. The following are additional examples of expenses or Services that are not Allowable Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.
- If a person is covered by two or more Coverage Plans that compute their benefit payments based on usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount more than the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not an Allowable Expense.
- If a person is covered by two or more Coverage Plans that provide benefits or Services based on negotiated fees, an amount more than the highest of the negotiated fees is not an Allowable Expense.
- If a person is covered by one Coverage Plan that calculates its benefits or Services based on usual and customary fees and another Coverage Plan that provides its benefits or Services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans. However, if the provider has contracted with the Secondary Coverage Plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Coverage Plan to determine its benefits.
- The amount a benefit is reduced by the Primary Coverage Plan because a covered person does not comply with the Coverage Plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

"Claim Determination Period" means a calendar year.

"Closed Panel Plan" is a Coverage 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 Coverage Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel member.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Coverage Plans which pay benefits, the rules for determining the order of payment are as follows:

- A. The Primary Coverage Plan pays or provides its benefits per its terms of coverage and without regard to the benefits of any other Coverage Plan(s).
- B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Coverage Plans state that the complying plan is primary; provided, however, coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written about a closed panel Coverage Plan to provide non-network benefits.
- C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
- D. Each Coverage Plan determines its order of benefits using the first of the following rules that applies:
 1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent, for example as an employee, member, subscriber, or retiree, is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, because of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent; and primary to the Coverage Plan covering the person as other than a Dependent (for example a retired employee), then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber, or retiree is secondary and the other Coverage Plan is primary.
 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Coverage Plan, the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together:

- (i) The Coverage Plan of the parent whose birthday falls earlier in the calendar year is primary
- (ii) If both parents have the same birthday, the Coverage Plan that has covered the parent the longest is primary.

b. For a dependent child whose parents are divorced or separated or are not living together:

(i) If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:

- The Coverage Plan of the custodial parent
- The Coverage Plan of the spouse of the custodial parent
- The Coverage Plan of the non-custodial parent, and then
- The Coverage Plan of the spouse of the non-custodial parent

c. For a dependent child covered under more than one Coverage Plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active or inactive (retired or laid-off) employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The Coverage Plan covering that same person as a retired or laid-off employee is the Secondary Coverage Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a dependent of a retiree or laid-off employee. If the other Coverage Plan does not have this rule, and thus, the Coverage Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber, or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and thus, the Coverage Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber, or retiree longer is primary and the Coverage Plan that covered the person the shorter period is the Secondary Coverage Plan.

6. If a husband or wife is covered under This Coverage Plan as an employee and as a Dependent (if the Plan's eligibility rules allow this), the benefits for the Dependent will be coordinated as if they were provided under another Coverage Plan. This means the Coverage Plan of the person as an Employee will pay first.

7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this "Coordination of Benefits" section. In addition, This Coverage Plan will not pay more than it would have paid had it been the Primary Coverage Plan.

Effect on the Benefits of this Plan

When This Coverage Plan is secondary, it may reduce its benefits so that the total amount of benefits paid or provided by all Coverage Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Coverage 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 Secondary Coverage Plan that is unpaid by the Primary Coverage Plan. The Secondary Coverage Plan may then reduce its

payment by the amount so that when combined with the amount paid by the Primary Coverage Plan, the total benefits paid or provided by all Coverage Plans for the claim do not exceed the total Allowable Expense for that claim.

If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of Service by a non-participating provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

This Coverage Plan complies with the Medicare Secondary Payer regulations. If a Covered Person is also receiving benefits under Medicare, including Medical Prescription Drug Coverage, federal law may require this Plan to be primary. When This Coverage Plan is not primary, the Plan will coordinate benefits with Medicare.

- To determine when Medicare is primary see the excerpt from <https://www.medicare.gov/publicationsbelow>:

How does my other insurance work with Medicare?

When you have other insurance (like group health plan, retiree health, or **Medicaid** coverage) and Medicare, there are rules for whether Medicare or your other coverage pays first.

If you have retiree health coverage (like insurance from your or your spouse's former employment)...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees ...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has fewer than 20 employees ...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees ...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has fewer than 100 employees ...	Medicare pays first.
If you have group health plan coverage based on your or a family member's employment or former employment, and you're eligible for Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan pays first for the first 30 months after you become eligible for Medicare. Medicare pays first after this 30-month period.
If you have TRICARE...	Medicare pays first, unless you're on active duty, or get items or services from a military hospital or clinic, or other federal health care provider.
If you have Medicaid...	Medicare pays first.

Important!

If you're still working and have employer coverage through work, contact your employer to find out how your employer's coverage works with Medicare.

Here are some important facts to remember about how other insurance works with Medicare-covered services:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary payer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your group health plan or retiree health coverage is the secondary payer, you might need to sign up for Part B before your insurance will pay.

Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet, "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can also call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Important!

If you have other insurance or changes to your insurance, you need to let Medicare know by calling Medicare's Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627.

If you have Part A, you may get a "Health Coverage" form (IRS Form 1095-B) from Medicare. This form verifies that you had health coverage in the past year. Keep the form for your records. Not everyone will get this form. If you don't get Form 1095-B, don't worry. You don't need it to file your taxes.

For more information on Medicare and ESRD see

<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD>

- The person is enrolled in a Medicare Advantage plan and receives non-Covered Services because the person did not follow all rules of that plan. Medicare benefits are determined as if the Services were covered under Medicare Parts A and B.
- The person receives Services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the Services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The Services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the Services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

Certain facts about health care coverage and Services are needed to apply these COB rules and to determine benefits payable under This Coverage Plan and other Coverage Plans. The Plan has the right to release or obtain any information and make or recover any payments considered necessary to administer this "Coordination of Benefits" section. This shall include getting the facts needed from, or giving them to, other organizations or persons for applying these rules and determining benefits payable under This Coverage Plan and other Coverage Plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Coverage Plan must provide any facts needed to apply those rules and determine benefits payable. If you do not provide the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, reimbursement to that Plan of that amount will be made to the Plan that made the payment. That amount will then be treated as though it was a benefit paid under This Plan and that amount will not be paid again. The term "payment made" includes providing benefits in the form of Services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of Services.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this "Coordination of Benefits" section, it may receive the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or Services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of Services.

Reductions

Subrogation and Reimbursement

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for damages or compensation due to a Covered Person as a result of a Covered Person's injuries, illness, or condition, including the liability insurer of such Responsible Party, or any insurance carrier providing medical expense or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative's other claims, regardless of whether

you are fully compensated for your damages. The Plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you or your dependent have been fully compensated. Neither the make-whole doctrine nor the common fund doctrine apply to the Plan.

The Plan shall be subrogated to all rights of recovery a Covered Person has against any Responsible Party with respect to any damages collected from a Responsible Party whether by action at law, settlement or compromise, by a Covered Person or his/her legal representative as a result of a Covered Person's injuries or illness, to the full extent of Benefits provided or to be provided by the Plan.

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from all Responsible Parties. Further, the Plan will automatically have a first priority equitable lien, to the extent of Benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a Covered Person receives from any Responsible Party as a result of the Covered Person's injuries, illness, or condition. The amount of the lien is equal to the amount of prior and future benefits paid by the Plan. The Plan also has a right to impose a constructive trust on the process awarded, transferred or paid by or on behalf of a third party to you, your dependents and any other person or entity holding the proceeds, including a legal representative or trust.

The Plan Administrator, or its delegate, has the sole authority and discretion to decide whether to pursue any right of recovery in favor of the Plan.

By accepting Benefits (whether the payment of such Benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

The terms of this entire subrogation and right of recovery provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical

Benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The Covered Person shall fully cooperate with the Plan's efforts to recover its Benefits paid. It is the duty of the Covered Person to notify the Plan within thirty (30) days of the date when any notice is given to any party, including an attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the Plan, the Claim Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health Benefits for the Covered Person or the institution of court proceedings against the Covered Person. The Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all Benefits provided by the Plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous, or if questions arise concerning the meaning or intent of any of its terms, the Plan Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting Benefits (whether the payment of such Benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Surrogacy arrangements

If you enter into a Surrogacy Arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, delivery, or postpartum care relating to that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A Surrogacy Arrangement is one in which a woman 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 woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Cost Sharing for these Services; you will be credited any such payments toward the amount you must reimburse the Plan under this paragraph. After you surrender a baby to the legal parents, you are not obligated to pay 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, you automatically assign to the Plan your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have an equitable 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 the Plan's lien will not exceed the total amount of your obligation to the Plan under the preceding paragraph.

Within 30 days after entering a Surrogacy Arrangement, you must send written notice of the arrangement, including all 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 the Plan may request to satisfy its rights to:

Health Plan Services
3701 Boardman-Canfield Rd., Bldg. B
Canfield, OH 44406-7005

You must complete and send all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary to determine the existence of any rights the Plan may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce the Plan's rights under this "Surrogacy Arrangements" section without the Plan's 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. The Plan may assign its rights to enforce its liens and other rights.

U.S. Department of Veterans Affairs

For any Services for conditions arising from military Service that the law requires the Department of Veterans Affairs to provide, the Plan will not pay the Department of Veterans Affairs, and when the Plan covers any such Services the Plan may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. The Plan will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but the Plan may recover the value of any covered Services from the following sources:

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

Dispute Resolution

Grievances

You may appoint an authorized representative to help you file your grievance. A written authorization must be received from you before any information will be communicated to your representative.

Kaiser Permanente is committed to providing quality care and a timely response to your concerns. You can discuss your concerns with our representatives at most Network Facilities, or you can call Customer Services at the number on your ID card.

You can file a grievance for any issue. Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility

Your grievance must explain your issue, such as the reasons why you are dissatisfied about Services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction.

Grievances may be submitted in one of the following ways:

- at a Kaiser Permanente Facility (please refer to www.kp.org for addresses)
- by calling Customer Service at the number on the back of your id card
- through www.kp.org

You will receive a confirmation letter within five days after receipt of your grievance. You will receive a written decision within 30 days after receipt of your grievance. Note: If your issue is resolved to your satisfaction by the end of the next business day after your grievance is received orally, or at www.kp.org, and a Customer Services representative notifies you orally about our decision, you will not receive a confirmation letter.

Legal Action

No legal action can be brought against the Plan to recover under any benefit after three (3) years from the deadline for filing claims or, if the claim does not relate to a claim for benefits subject to a deadline for filing claims under the Plan, within two years of the date when you knew or should have known of the actions or events giving rise to your claim.

Filing an Appeal

Eligibility for Coverage, Participation and Contributions

The Plan Administrator has the discretionary authority to make all determinations relating to eligibility for coverage, participation, contributions or other administrative aspects of the Plan. You may file a claim with regard to any of these administrative issues with the Plan Administrator and appeal adverse claim decisions to the Plan Administrator.

How to File Your Appeal?

To appeal an adverse administrative decision, submit your letter of appeal and any pertinent documents via regular mail to:

Emory University
Benefits and Work Life Department
Official Appeal
1599-001-1AP
1599 Clifton Road NE
Atlanta, Georgia 30322

or by fax to:

Emory University
Benefits and Work Life Department
Official Appeal
(404) 727-7145

or as an attachment by email to:

hrbenef@emory.edu

Your appeal request should include your name, employee number and any other comments, documents, records and/or other information you would like to have considered, whether or not submitted originally. You will have 180 days from receiving notification of a denial of eligibility for coverage, participation and/or contributions to file an appeal with the Plan Administrator. Your appeal will be acknowledged within 15 working days of receipt. You will be notified of a decision with regard to your appeal not later than 30 days after the appeal is received. This period may be extended up to 15 days and a representative of the Plan

Administrator will contact you to indicate a delay with regard to a determination of your appeal.

If you are dissatisfied with an appeal decision, you may file a second-level appeal with the Plan Administrator within 60 days of receipt of the decision with regard to your first appeal. The Plan Administrator will notify you of the decision with regard to your second appeal not later than 45 days after the appeal is received. Health Plan Appeals for Claims Payment.

To obtain payment for Services you have paid for or to obtain review of a claims payment decision, you must follow the procedures outlined in this “CLAIMS AND APPEALS” section. You may appoint an authorized representative to help you file a claim or appeal. A written authorization must be received from you before any information will be communicated to your representative.

If you miss a deadline for filing a claim or appeal, review may be declined. Before you can file a civil action, you must meet any deadlines and exhaust the claims and appeals procedures set forth in this “CLAIMS AND APPEALS” section. There is no charge for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

Timing of Claim Determinations

The Plan adheres to certain time limits when processing claims for benefits. If you do not follow the proper procedures for submitting a claim, KPIC will notify you of the proper procedures within the time frames shown in the chart below. If additional information is needed to process your claim, KPIC will notify you within the time frames shown in the chart below, and you will be provided additional time within which to provide the requested information as indicated in the chart below in this [“Timing of Claim Determinations”](#) section.

Determination on your claim will be made within the time frames indicated below based upon the type of claim: Urgent Claim, Pre-Service Claim, Post-Service Claim, or Concurrent Care Claim.

An “Urgent Care Claim” is any claim for a Service with respect to which the application of the time periods for making non-urgent care determinations either (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 that are the subject of the claim, or a claim that your attending provider determines is urgent.

A “Pre-Service Claim” is any claim for a Service with respect to which the terms of the Plan condition receipt of the Service, in whole or in part, on approval of the Service in advance.

A “Post-Service Claim” is any claim for a Service that is not a Pre-Service Claim, a Concurrent Care Claim, or an Urgent Care Claim.

A “Concurrent Care Claim” is any claim for Services that are part of an on-going course of treatment that was previously approved for a specific period or number of treatments.

Type of Notice or Claim Event*	Urgent Care Claim	Pre-Service Care Claim	Post-Service Care Claim
Notice of Failure to Follow the Proper Procedure to File a Claim	Not later than 24 hours after receiving the improper claim.	Not later than 5 days after receiving the improper claim.	Not applicable.
Notice of Initial Claim Decision	<p>If the claim when initially filed is proper and complete, a decision will be made as soon as possible, considering the medical exigencies, but not later than 72 hours after receiving the initial claim.</p> <p>If the claim is not complete, the KPIC will notify you as soon as possible, but not later than 24 hours of receipt of the claim. You will have 48 hours to provide the information necessary to complete the claim. A decision will be made not later than 48 hours after the administrator receives the requested information, or within 48 hours after the expiration of the 48-hour deadline for submitting additional information, whichever is earlier.</p>	<p>If the claim when initially filed is proper and complete, a decision will be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control of the Plan. You will be notified within the initial 15 days if an extension will be needed. The notice will state the reason for the extension.</p> <p>A decision will be made not later than 15 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information, or within 15 days after the expiration of the 45-day deadline for submitting additional information, whichever is earlier.</p>	<p>A decision will be made within a reasonable amount of time, but not later than 30 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond KPIC’s control. You will be notified within the initial 30 days if an extension will be needed. The notice will state the reason for the extension.</p> <p>A decision will be made not later than 30 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 30-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information or, within 15 days after the expiration of the 45-day deadline for submitting additional information, whichever is earlier.</p>

* All listed time frames are calendar days

Concurrent Care Claims

If you have a Concurrent Care Claim that is also an Urgent Care Claim to extend a previously approved on-going course of treatment provided over a period of time or number of treatments, KPIC will make a determination as soon as possible, taking into account the medical exigencies, and notify you of the determination within twenty-four (24) hours after receipt of the claim, provided that the claim was made to KPIC at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments previously approved. If your request for extended treatment is not made at least twenty-four

(24) hours prior to the end of the prescribed period or number of treatments, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If your Concurrent Care Claim is not an Urgent Care Claim, and there is a reduction or termination of the previously approved on-going course of treatment provided over a period of time or number of treatments (other than by Plan amendment or termination) before the end of the period of time or number of treatments, you will be notified by KPIC sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit.

Post Service Claims

To obtain payment for Services you have paid for or to obtain review of a claims payment decision, you must follow the procedures outlined in this “**Error! Reference source not found.**” section.

If you miss a deadline for filing a claim or appeal, review may be declined. Before you can file a civil action under ERISA section 502(a)(1)(B), you must meet any deadlines and exhaust the claims and appeals procedures set forth in this “**Error! Reference source not found.**” section. There is no charge for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

How to File a Claim

Network Providers are responsible for submitting claims for their Services on your behalf and will be paid directly for the Services they render. If a Network Provider bills you for a Covered Service (other than for Cost Sharing), please call Customer Service at the telephone number listed in the “Customer Service Phone Numbers” section.

For Services rendered by Non-Network providers, where the provider agrees to submit a claim on your behalf, eligible claims payment to the provider will require you to direct that benefit payment on your behalf be paid directly to the provider (assignment of benefits). Even if the Non-Network Provider agrees to bill on your behalf, you are responsible for making sure that the claim is received within 365 days of the date of Service and that all information necessary to process the claim is received.

To receive reimbursement for Services you have paid for, you must complete and mail a claim form or (or write a letter) to the Claims Administrator at the address listed in the “Customer Service Phone Numbers” section, **within 365 days after you receive Services**. The claim form (or letter) must explain the Services, the date you received them, where you received them, who provided them, and why you think the Plan should pay for them. Include a copy of the bill

and any supporting documents. Your claim form (or letter) and the related documents constitute your claim.

Your claim must include all the following information:

- Patient name, address, and Kaiser Permanente ID card medical or health record number
- Date(s) of Service
- Diagnosis
- Procedure codes and description of the Services
- Charges for each Service
- The name, address, and tax identification number of the provider
- The date the injury or illness began
- Any information regarding other medical coverage

To obtain a medical or pharmacy claim form, visit the Kaiser Permanente Web site at www.kp.org, log in, and then go to *My Health Manager* then *My Plan and Coverage*, then select the bullet *Claims Summary*. The claim form will inform you about other information that you must include with your claim.

If KPIC pays a Post-Service Claim, it will pay you directly, except that it will pay the provider if your claim includes a written request to pay your benefits directly to the provider (assignment of benefits) or before the claim is processed, a written notice is received indicating you have assigned your right to payment to the provider.

Restrictions Against Assignment of Benefits

Benefits, rights and interests under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, or execution of levy of any kind, either voluntary or involuntary, by any person, and any such attempts shall be void. However, a Participant may direct that benefits payable to him be paid to an institution in which he or his covered Dependent is hospitalized or to any other provider of Services or supplies authorized under this Plan. Notwithstanding the foregoing, the Plan reserves the right to refuse to honor such direction and to make payment directly to the Participant. No payment by the Plan pursuant to such direction shall be considered recognition by the Plan of a duty or obligation to pay a provider of Services or supplies except to the extent the Plan actually chooses to do so.

If you have any questions about submitting a claim for payment for a Service from a Non-Network Provider, please call Customer Service at the telephone number listed on your ID card or in the “Customer Service Phone Numbers” section.

If a Claim Is Denied

If all or part of your claim is denied, KPIC will send you a written notice. If the notice of denial involves an Urgent Care Claim, the notice may be provided orally

(a written or electronic confirmation will follow within 3 days). This notice will explain:

- The reasons for the denial, including references to specific Plan provisions upon which the denial was based;
- If the claim was denied because you did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the claim and an explanation of why the information or materials are necessary;
- If the claim is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request;
- The notice will also state how and when to request a review of the denied claim,
- If applicable, the notice will also contain a statement of your right to bring a civil action under Section 502(a) of ERISA of an adverse benefit determination following completion of all levels of review; and
- The availability of and contact information for, any applicable office of health insurance consumer assistance ombudsman.

Note: You have the right to request any diagnostic and treatment codes and their meanings that may be the subject of your claim. To make such a request, contact Customer Service at the number on your identification card.

How to Appeal a Denied Claim

You may appeal a denied claim by submitting a written request for review to the Plan. You must make the appeal request within 180 days after the date of the denial notice. Send the written request to the Plan at:

For **Pre-Service and Concurrent Care Denials** send your written appeal to the address that corresponds to the region in which you receive your care:

California	Colorado
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Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	Mid-Atlantic (DC, MD, VA)
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710 1-888-225-7202
Northwest	Washington
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 1-866-616-0047	Kaiser Permanente Appeals P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Tol-Free 1-866-458-5479 Fax 206-630-1859
Cigna Providers Pre-Service Appeals – Not applicable to WA and NW members	
Cigna Medical UM Appeals Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 Appeals Fax Number: 1-877-804-1679	Cigna Behavioral UM Appeals Attn: Appeals P.O. Box 23487 Chattanooga, TN 37422-3487 Appeals Fax Number: 1-855-816-3497

Or for Urgent appeals submitted over the phone call:

Oral Appeal	Cigna Providers Pre-Service Appeals – Not applicable to WA and NW members
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card	1-866-494-4872

The request must explain why you believe a review is in order and it must include supporting facts and any other pertinent information. The Plan may require you to submit such additional facts, documents, or other material as it may deem necessary or appropriate in making its review.

In addition, under Public Health Service Act (PHS ACT) Section 279.3, states with Consumer Assistance Programs may be available in your state to assist you in filing your appeal. A list of state Consumer Protection Agencies is available on www.kp.org (Log into My Health Manager, select Manage My Plan & Coverage, then click on Claims Summary list of the State Assistance Programs under the Resources banner) or <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting>.

Deemed Exhaustion

If the Plan does not adhere to the Appeals process as described below, it will be deemed that you have exhausted the appeals process. This means that you are no longer required to stay within the mandated internal appeal process.

Exception:

- Violations which do not cause and are not likely to cause prejudice or harm and,
- Can be demonstrated were for good cause or due to matters beyond the control of the Plan and,
- The violation occurred in the context of an on-going, good faith exchange of information between the Plan and you.

You may request a written explanation of the violation and it will be provided to you within 10 days of your request. Such explanation will include a specific description of the basis, if any, on which the appeal process is not deemed to be exhausted. If an external review organization or court determines your appeal is not deemed exhausted, you have the right to resubmit your appeal request and continue the internal appeal process.

Procedures on Appeal

As part of the review procedure, you may submit written comments, documents, records, and other information relating to the claim.

Also, you may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in our acknowledgement letter, sent to you within five days after we receive your appeal. To arrange to give testimony by telephone, you should call the phone number mentioned in our acknowledgement letter. We will add the information that you provide through testimony or other means to your appeal file, and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services.

Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim.

The Plan will review the claim, considering all comments, documents, records, and other information submitted relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial claim denial and will be conducted by the Claims Fiduciary (named in the “Legal and Administrative Information” section), who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary, the Claims Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and that health care professional will not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal (or the subordinate of that individual).

Upon request, the Plan will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan about the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

Timing of Initial Appeal Determinations

Plan will act upon each request for a review within the time frames indicated in the chart below:

Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Not later than 72 hours after receiving the appeal.	Not later than 15 days after receiving the appeal	Not later than 30 days after receiving the appeal.

* All listed time frames are calendar days

Notice of Determination on Initial Appeal

Within the time prescribed in the “Timing of Initial Appeal Determinations” section, Plan will provide you with written notice of its decision. If the Plan determines that benefits should have been paid, the Plan will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice will state:

- The reasons for the denial, including references to the specific Plan provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse

determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.

- If the claim is denied based on a Medical Necessity, Experimental, or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.
- For Pre-Service Claims and Post-Service Claims, the notice will also state how and when to request a review of the denial of the initial appeal.
- For Urgent Care Claims, the notice will also describe any voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures.
- The notice will also include a statement of your right to bring an action under section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

How to File a Final Appeal

For Pre-Service Claims and Post-Service Claims, you may appeal the denial of your initial appeal by submitting a written request for review to the Plan. You must make the appeal request within 180 days after the date of notice that your initial appeal is denied. Send the written request to the Plan at:

For **Pre-Service and Concurrent Care Denials** send your written appeal to the address that corresponds to the region in which you receive your care:

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	Mid-Atlantic (DC, MD, VA)
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710 1-888-225-7202
Northwest	Washington
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 1-866-616-0047	Kaiser Permanente Appeals P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Tol-Free 1-866-458-5479 Fax 206-630-1859

Cigna Providers Pre-Service Appeals – Not applicable to WA and NW members	
Cigna Medical UM Appeals Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 Appeals Fax Number: 1-877-804-1679	Cigna Behavioral UM Appeals Attn: Appeals P.O. Box 23487 Chattanooga, TN 37422-3487 Appeals Fax Number: 1-855-816-3497

Or for Urgent appeals submitted over the phone call:

Oral Appeal	Cigna Providers Pre-Service Appeals – Not applicable to WA and NW members
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card	1-866-494-4872

Timing of Final Appeal Determinations

For Pre-Service Claims and Post-Service Claims, the Plan will act upon each request for a review of the denial of your initial appeal within the time frames indicated in the chart below:

Pre-Service Claim	Post-Service Claim
Not later than 15 days after the appeal is received.	Not later than 30 days after the appeal is received.

* All listed time frames are calendar days

Notice of Determination on Final Appeal

Within the time prescribed in the “Timing of Final Appeal Determinations” section, the Plan will provide you with written notice of its decision. If the Plan determines that benefits should have been paid, the Plan will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice will state:

- The reasons for the denial, including references to specific Plan provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a Medical Necessity, Experimental treatment or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination,

applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.

- Any voluntary appeal procedures offered by the Plan and your right to obtain the information about those procedures.
- The notice will also include a statement of your right to bring an action under section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

Next Steps

If after exhausting the appeals process, you are still not satisfied, your remaining remedies include the right to sue in Federal Court under Section 502(a) of ERISA and voluntary dispute resolution options, such as mediation or independent External Review as described below.

External Review

Your request for external review **must be filed within four months** after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

To request an independent external review of Plan denials, complete the External Review request form on www.kp.org and send the written request to:

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	Mid-Atlantic (DC, MD, VA)
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710 1-888-225-7202
Northwest	Washington

<p>Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 1-866-616-0047</p>	<p>Kaiser Permanente Appeals P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Tol-Free 1-866-458-5479 Fax 206-630-1859</p>
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Cigna Providers Pre-Service Appeals – Not applicable to WA and NW members	
Cigna Medical UM Appeals Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 Appeals Fax Number: 1-877-804-1679	Cigna Behavioral UM Appeals Attn: Appeals P.O. Box 23487 Chattanooga, TN 37422-3487 Appeals Fax Number: 1-855-816-3497

Or for Urgent appeals submitted over the phone call:

Oral Appeal	Cigna Providers Pre-Service Appeals – Not applicable to WA and NW members
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card	1-866-494-4872

Preliminary Review of External Review Request

Within five business days following the date of receipt of the external review request, KPIC will complete a preliminary review of the request to determine whether:

- (a) The claimant is or was covered under the Plan at the time the health care item or Service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or Service was provided;
- (b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- (c) The claimant has exhausted the Plan’s internal appeal process unless the claimant is not required to exhaust the internal appeals process; and
- (d) The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, KPIC will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete and KPIC will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

KPIC will assign an independent review organization (IRO) that is accredited by URAC (Utilization Review Accreditation Commission) or by similar nationally recognized accrediting organization to conduct the external review. Moreover, KPIC will act to guard against bias and to ensure independence. Accordingly, KPIC will maintain contracts with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random

selection). In addition, the IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support a denial of benefits.

Contracts between KPIC and IROs will provide for the following:

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit, within ten business days following the date of the receipt of the notice, additional information for the assigned IRO to use when conducting the external review. Additional information must be submitted in writing to the assigned IRO. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(c) Within five business days after the date of assignment of the IRO, KPIC will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by KPIC to timely provide the documents and information will not delay the conduct of the external review. If KPIC fails to timely provide the documents and information, the assigned IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making its decision, the IRO will notify the claimant and KPIC of that decision.

(d) Upon receipt of any information submitted by the claimant, the IRO will within one business day forward the information to KPIC. Upon receipt of any such information, KPIC may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by KPIC will not delay the external review. The external review may be terminated because of the reconsideration only if KPIC decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, KPIC will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from KPIC.

(e) The IRO will review all the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the internal claims and appeals process applicable under section 2719 of the PHS Act. In addition to the document and information provided, the assigned IRO, to the extent information or documents is available and the assigned IRO considers them appropriate, the IRO will consider the following in reaching a decision:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or the claimant's treating provider;

- The terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which will include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan, the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO will deliver the notice of final external review decision to the claimant and the Plan.

(g) The assigned IRO's decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of Service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning (if applicable), the treatment code and its corresponding meaning (if applicable), and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the documentation, considered, including the specific coverage provision and evidence-based standards considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards, that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under Federal (or possibly state) law to either the Plan or to the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable ombudsman established under the PHS Act section 2793.

(h) After a final external review decision, the IRO will retain records of all claims and notices associated with the external review process for six years. The IRO will make such records available for examination by the claimant, Plan or

Federal oversight agency upon request, except where such disclosure would violate Federal privacy laws.

Reversal Of Plan's Decision

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, KPIC will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim as directed by the IRO.

Expedited External Review

If after exhausting of the internal Urgent Appeal process, you are still not satisfied, you may be eligible for an expedited external appeal.

Request For Expedited External Review

KPIC will allow a claimant to make a request for an expedited external review at the time the claimant receives:

(a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal or

(b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or Service for which the claimant received emergency Services, but has not been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, KPIC will determine whether the request meets the reviewability requirements set forth above for standard external review. KPIC will immediately send a notice that meets the requirements set forth above for standard external review to the claimant or its eligibility determination.

Referral To Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, KPIC will assign an IRO pursuant to the requirements set forth above for standard review. KPIC will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice Of Final External Review Decision

KPIC's contract with the assigned IRO requires the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and Plan.

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including 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.

Termination of Coverage

Your current coverage under the Plan will end on the last day of the month in which one of the following events occurs:

- You are no longer employed by Emory (unless you qualify and enroll as a retiree, and make the required payments);
- You lose your eligibility under the Plan (including on account of a reduction in hours);
- You revoke your election for coverage (which generally must be made prospectively) provided such revocation is otherwise permitted under the terms of the Plan; or
- You stop paying for your coverage.

Your coverage will also terminate on the date on which the Plan is terminated or amended to exclude coverage for you or the class in which you are a member.

Your dependent's coverage will end on the last day of the month that:

- Your coverage ends;
- You die;
- Your dependent loses his or her eligibility under the Plan (including on account of a divorce or your Dependent child aging out of the Plan); or
- The effective date of any election you make to revoke your Dependent's coverage (which generally must be made prospectively) provided such revocation is otherwise permitted under the terms of the Plan.

Note: If you stop making contributions, your coverage will end on the last day of the month for which a full contribution was credited.

In certain situations, you and/or your Dependent may be eligible to elect to continue your coverage under the Plan when it is lost for one or more of the reasons described above. For additional information, you should review the section of this SPD titled "Continuation of Coverage."

For Cause

Upon written notice to the Participant, the eligibility of the Participant and his or her dependents may be immediately terminated if the Participant or Dependent(s):

- (1) Threaten the safety of the Administrator or Provider personnel or any person or property at a Network Facility.
- (2) Commit theft from the Administrator or Network Provider or at a Network Facility.
- (3) Performs an act that constitutes fraud or makes an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) misrepresenting participation status, (2) presenting an

invalid prescription or physician order, or (3) misusing or letting someone else misuse an ID card or Medical Record Number to obtain care under false pretenses. Note: Any Participant's or Dependent's fraud will be reported to the authorities for prosecution and appropriate civil remedies will be pursued.

Termination will be effective on the date notice is sent. All rights cease as of the date of termination, including the right to convert to non-group coverage.

Rescission of Medical Coverage

Once your Plan coverage is effective, your medical coverage cannot be rescinded unless you or a covered dependent performs an act, practice or omission that constitutes fraud or unless you or a covered dependent makes an intentional misrepresentation of a material fact. A rescission is a cancellation, discontinuance or termination of medical coverage that has a retroactive effect. The Plan will provide you at least 30 days' advance written notice if your medical coverage will be rescinded. Any rescission of medical coverage is subject to the Claims and Appeals procedures.

For this purpose, the following are treated as intentional misrepresentation or fraud (unless prohibited by applicable law):

- Providing Emory, the Plan Administrator or the Plan with false or misleading information regarding a spouse or dependent child (e.g., incorrect name or social security number);
- Enrolling an individual who does not satisfy the eligibility criteria;
- Failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria (e.g., following divorce);
- Filing or participating in filing a false or misleading claim for benefits;
- Allowing your ID card to be used by an individual who is not enrolled in the Plan; or
- Any other act, practice or omission that constitutes intentional misrepresentation or fraud as determined by the Plan Administrator (unless prohibited by applicable law).

However, the rescission rules described above do not apply in the following situations:

- If you fail to timely pay required contributions towards the cost of your coverage, your coverage can be terminated retroactively; or
- If your coverage is terminated prospectively; or
- As otherwise permitted by law.

Continuation of Coverage

COBRA Continuation Coverage

This summary contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This summary generally explains COBRA continuation coverage, when it may become available to you and your Dependents, if any, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your eligibility for coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan's COBRA Administrator.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this "[COBRA Continuation Coverage](#)" section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Participants and Dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualifying Events

If you are a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- The Participant dies
- The Participant's hours of employment are reduced
- The Participant's employment ends for any reason other than his or her gross misconduct
- The Participant becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse, the Participant

If you are the Dependent (other than a spouse) of a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- The parent-Participant dies
- The parent-Participant's hours of employment are reduced
- The parent-Participant's employment ends for any reason other than his or her gross misconduct
- The parent-Participant becomes entitled to Medicare benefits (under Part A, Part B, or both)
- The parents become divorced or legally separated
- You lose eligibility under the Plan as a Dependent

Election of COBRA Coverage and Notice of Qualifying Event

The Plan will offer qualified beneficiaries the opportunity to elect COBRA continuation coverage only after the Plan's COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the termination of the Participant's employment (except when it is for gross negligence) or a reduction of hours of Participant's employment, the death of the Participant, commencement of a proceeding in bankruptcy with respect to the Plan Sponsor, or the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Sponsor must notify the Plan's COBRA Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the Participant and his or her spouse or a Dependent's loss of eligibility under the Plan as a Dependent), the Participant must notify the Plan's COBRA Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan's COBRA Administrator:

McGriff Insurance
12725 Morris Road Extension, Suite 100
Alpharetta, GA 30004

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In cases of loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits within 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Once the McGriff Insurance Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right

to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation of the Participant and his or her spouse, or a Dependent's loss of eligibility under the Plan as a Dependent, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of the Participant's employment or reduction of the Participant's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, when the qualifying event is the end of the Participant's employment or reduction of the Participant's hours of employment, AND the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a Participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Extension of COBRA Continuation Coverage

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

First, if the Participant or his or her Dependents covered under the Plan is determined by the Social Security Administration to be disabled and the Plan's COBRA Administrator is notified in a timely manner, the Participant and all his or her Dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

“An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify McGriff of the SSA's determination before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer

be disabled, you must notify McGriff of that fact within 30 days of SSA's determination."

Second, if another qualifying event (as explained later in this paragraph) occurs while receiving 18 months of COBRA continuation coverage, then the spouse and Dependent children may qualify for up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is transmitted to the Plan. This extension may be available to the spouse and other Dependents receiving COBRA continuation coverage if the Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child loses eligibility under the Plan as a Dependent child.

This extension of COBRA continuation coverage can occur only if the event would have caused the Spouse or other Dependent to lose coverage under the Plan had the first qualifying event not occurred.

In order to protect your rights, you should keep the Plan Administrator informed of any changes in your address. You should also keep a copy, for your records, of any notices you send to the McGriff Insurance Plan Administrator.

Questions relating to the Plan or your right to COBRA continuation coverage should be address to the Plan's COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

USERRA Continuation Coverage

If you or your dependents lose coverage under the Plan due to your qualifying service in the uniformed services, you have the right to elect to continue such coverage under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To be entitled to USERRA rights, you must give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Service in the uniformed services includes duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances, where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures, which govern your right to COBRA continuation

coverage, also apply to your right to USERRA continuation coverage, with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any covered dependents. Your covered dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your covered dependents, your covered dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue health coverage for yourself (or your covered dependents) under USERRA, you must pay 102% of the full premium elected (the same rate as COBRA) at the same time as the premium for COBRA coverage is due. However, if your uniformed service period is less than 31 days, you are not required to pay more for health coverage than you would be required to pay as an active employee.

USERRA continuation coverage will generally continue for up to 24 months following the date your leave of absence begins. However, this coverage will terminate earlier if any one of the following events occurs:

- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early, but which do not cause COBRA coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued health coverage under COBRA.

Continuity of Care

Your Plan uses Network providers to provide Plan benefits. Should a Network Provider contract terminate, Continuing Care Patients of the terminated provider have a right to elect to continue transitional care from that terminated provider under the same terms and conditions for the earlier of 90-days or until you are no longer a Continuing Care Patient.

- a) A Continuing Care Patient is an individual who, with respect to a provider:
 - Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- b) Is undergoing a course of institutional or inpatient care from the provider or facility;
- c) Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- d) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- e) Is or was determined to be terminally ill (as determined under specified Medicare rules) and is receiving treatment for such illness from such provider or facility.

Miscellaneous Provisions

Overpayment Recovery

Any overpayment made for Services will be recovered from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Qualified Medical Child Support Order

The Plan will provide coverage as required by any qualified medical child support order ("QMCSO"), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of these procedures from the Plan Administrator.

ERISA Notices

Newborn Baby and Mother Protection Act

Group health plans, such as the Plan, generally may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting

with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not more than 48 hours (or 96 hours). Coverage of childbirth hospital Services is subject to all provisions of this SPD, such as the provisions concerning exclusions and Cost Sharing.

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 group health plans that provide coverage for a mastectomy must also provide coverage for the following Services:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Protheses
- Treatment of physical complications of the mastectomy, including lymphedema

The Plan covers mastectomies and related Services subject to all provisions of this Plan document, such as the provisions concerning exclusions and Copayments.

Your ERISA Plan

The Plan is a welfare benefit plan covered under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). As a participant in an ERISA-covered Plan, you are entitled to certain rights and protections. ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, annual reports, and copies of all documents filed by the Plan with the U.S. Department of Labor, that are available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents, including the most recent version of the SPD (Summary Plan Description), annual reports, and other Plan information, upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents

governing the Plan for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under this Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, and when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your subsequent coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the Plan Participants and Dependents. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan, or from exercising your rights under ERISA.

If your request (claim) for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials (Plan documents and the latest annual report) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a request for benefits which is denied or ignored in whole or part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this part of the Summary Plan

Description or about your rights under ERISA or if you need assistance in obtaining Plan documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Plan may be discontinued, altered, or modified, in whole or in part, at any time and for any reason, at its sole determination. The decision to terminate or amend the Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A change to the Plan may involve the transfer of assets and debts to another plan or a split of the Plan into two or more parts. If the Plan does change or terminate, a new plan may be established.

If this Plan is terminated, you will not have the right to any other Plan benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, the Plan benefits may be changed. The amount and form of any final benefit you receive will depend on any Plan document or contract provisions. After all claims for Plan benefits have been paid and other legal requirements have been met, then certain assets of the Plan will be distributed to the Plan Sponsor and any other party as may be required by any applicable law.

This SPD represents an overview of your Plan benefits. In the event there is a discrepancy between this SPD and the official Plan document, the Plan document will govern. Copies of these documents, as well as the latest summary annual reports of Plan operations and Plan descriptions as filed with the Internal Revenue Service and the U.S. Department of Labor, are available for your inspection during regular business hours in the office of the Plan Administrator. You may obtain a copy of these documents by written request to the Plan Administrator, for a nominal charge.

Legal and Administrative Information

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Name: Emory University Healthcare Plan
Plan Sponsor: Emory University
Attn: Sr. VP & Chief HR Officer
1599 Clifton Road NE, First Floor
Atlanta, GA 30322

Employer Identification Number: 58-0566256
Plan Number: 502

Plan Year: January 1 – December 31

Type of Plan: Welfare (Self-funded Medical Benefit Plan)
Type of Administration: Administrative Services Contract with the following claims administrators:

KPIC Self-Funded Claims Administrator
P.O. Box 30547
Salt Lake City, UT 84130-0547

OptumRx Claims Department
P.O. Box 29044
Hot Springs, AR 71903

Claims Fiduciary: Health Plan Services
3701 Boardman-Canfield Road
Canfield, Ohio 44406

Plan Administrator: Emory University
Attn: Sr. VP & Chief HR Officer
1599 Clifton Road NE, First Floor
Atlanta, GA 30322

Funding Medium: Self-funded; paid from general assets

Source of Contributions: Participants and Emory share in the cost of this Plan

Agent for Service of Legal Process: Emory University

Office of the General Counsel
201 Dowman Drive
101 Administration Building
Atlanta, GA 30322

Procedure for Amending the Plan:

Emory may amend the Plan at any time, by a written instrument signed by a senior officer of Emory University. Some terms are described only in the document and the document can be revised at any time (without a formal amendment to the Plan)

Trustee:

Emory University
Attn: Sr. VP & Chief HR Officer
1599 Clifton Road NE, First Floor
Atlanta, GA 30322

Service Areas

Participants must live or work in a Kaiser Service Area at the time of enrollment. You cannot continue enrollment as a Participant if you move outside a Kaiser Permanente Service Area. To verify your zip code visit <https://individual-family.kaiserpermanente.org/healthinsurance>

Service Areas for Georgia

COUNTY	ZIP
BARROW	BOGART, AUBURN, BRASELTON, HOSCHTON, BETHLEHEM, STATHAM, WINDER, MONROE
BARTOW	ADAIRSVILLE, ARAGON, CARTERSVILLE, CASSVILLE, EMERSON, KINGSTON, ROME, RYDAL, WALESKA, WHITE, ACWORTH, CARTERSVILLE, DALLAS, TAYLORSVILLE, FAIRMOUNT
BUTTS	FLOVILLA, FORSYTH, JENKINSBURG, JACKSON, MCDONOUGH, GRIFFIN, LOCUST GROVE, GRIFFIN
CARROLL	BOWDON JUNCTION, CARROLLTON, MOUNT ZION, WHITESBURG, WINSTON, VILLA RICA, BREMEN, WACO, BOWDON, TEMPLE, ROOPVILLE
CHEROKEE	CANTON, HOLLY SPRINGS, LEBANON, NELSON, WOODSTOCK, MARIETTA, WOODSTOCK, ROSWELL, CUMMING, DAWSONVILLE, JASPER, CUMMING, ALPHARETTA, BALL GROUND
CLARKE	ATHENS, ATHENS, HULL, WINTERVILLE, WATKINSVILLE
CLAYTON	ATLANTA, FOREST PARK, JONESBORO, LOVEJOY, MORROW, RIVERDALE, CONLEY, ELLENWOOD, FAYETTEVILLE, JONESBORO, REX, STOCKBRIDGE, HAMPTON
COBB	AUSTELL, POWDER SPRINGS, ATLANTA, DALLAS, HIRAM
COWETA	HARALSON, MORELAND, NEWNAN, SARGENT, SHARPSBURG, TURIN, SENOIA, PALMETTO, NEWNAN, HOGANVILLE, GRANTVILLE
DAWSON	ELLIJAY, DAHLONEGA, MARBLE HILL
DEKALB	ATLANTA, AVONDALE ESTATES, CLARKSTON, DECATUR, LITHONIA, PINE LAKE, REDAN, SCOTTDALE, STONE MOUNTAIN, TUCKER, SNELLVILLE, CONYERS
DOUGLAS	DOUGLASVILLE, LITHIA SPRINGS
FAYETTE	PEACHTREE CITY, TYRONE, FAYETTEVILLE, BROOKS
FORSYTH	CUMMING, ALPHARETTA, DULUTH, SUWANEE, GAINESVILLE
GWINNETT	BUFORD, DULUTH, GRAYSON, LAWRENCEVILLE, LILBURN, NORCROSS, NORTH METRO, SNELLVILLE, BUFORD, LOGANVILLE, DACULA
HALL	ALTO, CHESTNUT MOUNTAIN, CLERMONT, CORNELIA, FLOWERY BRANCH, GAINESVILLE, GILLSVILLE, LULA, MURRAYVILLE, OAKWOOD, PENDERGRASS, TALMO
HARALSON	BUCHANAN, CEDARTOWN, FELTON, TALLAPOOSA, ROCKMART
HEARD	FRANKLIN, LAGRANGE
HENRY	MCDONOUGH
LAMAR	BARNESVILLE, CULLODEN, YATESVILLE, MEANSVILLE, MILNER, THE ROCK, ZEBULON
MADISON	CARLTON, COLBERT, COMER
MERIWETHER	GAY, GREENVILLE, LUTHERSVILLE, MANCHESTER, PINE MOUNTAIN, WARM SPRINGS, WOODBURY
NEWTON	COVINGTON, MANSFIELD, NEWBORN, PORTERDALE, CONYERS, COVINGTON, OXFORD, SOCIAL CIRCLE
OCONEE	BISHOP, FARMINGTON, HIGH SHOALS, ARNOLDSVILLE
OGLETHORPE	CRAWFORD, LEXINGTON, MAXEYS, RAYLE, STEPHENS, UNION POINT

PICKENS	RANGER, TALKING ROCK, TATE
PIKE	CONCORD, MOLENA, WILLIAMSON
SPALDING	EXPERIMENT, ORCHARD HILL, SUNNY SIDE
WALTON	GOOD HOPE, JERSEY, MADISON, MONROE, RUTLEDGE

Customer Service Phone Numbers

General Customer Service

Northern California Region	800-663-1771
Southern California Region	800-533-1833
Colorado Region	877-883-6698
Mid-Atlantic States Region	877-740-4117
Northwest Region	866-800-3402
Georgia Region	866-800-1486
Washington & Eastern Idaho	877-721-2199

Utilization Management for Out-of-Network Emergency Services

Northern California Region	800-225-8883
Southern California Region	800-225-8883
Colorado Region	303-338-3800
Mid-Atlantic States Region	800-810-4766
Northwest Region	866-813-2437
Georgia Region	800-221-2412
Washington & Eastern Idaho	800-289-1363
Cigna Payor Solutions	888-831-0761

Advice Nurses

Northern California Region	866-454-8855
Southern California Region	888-576-6225
Colorado Region	866-311-4464
Mid-Atlantic States Region	703-359-7878
(Outside Washington Metro Area)	800-777-7904
Northwest Region	503 813-2000
Outside Portland	800 813-2000
Georgia Region	800-611-1811
Washington & Eastern Idaho	800-297-6877

Interpreter Services

Northern California Region	800-663-1771
Southern California Region	800-533-1833
Colorado Region	877-883-6698
Mid-Atlantic States Region	877-740-4117
Northwest Region	866-800-3402
Washington & Eastern Idaho	866-213-3062

TTY

771 or 877-870-0283

Pharmacy Benefit Information


All Regions	866-427-7701
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Claims Administrator:

KPIC Self-Funded Claims Administrator
P.O. Box 30547
Salt Lake City, UT 84130-0547
Payor ID # 94320

Submitting a Claim

Network Providers will submit claims on your behalf. Should you receive care from a Non-Network Provider, submit a claim for reimbursement on-line by logging into kp.org then use the search function to search for “claim form”.

☰

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Submit a Claim

Submit Reimbursement for COVID-19 at Home Test Kit

Your reimbursement claim will be processed by the Pharmacy Benefit Manager (OptumRX). You will be submitting the reimbursement request directly on their web portal.

By submitting a claim for reimbursement, you are attesting that the self-test was purchased for personal use, is not for employment purposes unless required by applicable state law, has not and will not be reimbursed by another source, and is not for resale.

[Submit Reimbursement Claim Online](#) ↗

Submit a Medical Claim

[Submit Medical Claim Online](#)

Or you may print and complete a [Medical Claim Form \(PDF\)](#), then mail to:

Kaiser Permanente Insurance Company (KPIC)
Claims Administrator
P.O. Box 30547
Salt Lake City, UT 84130-0547

To view your Medical Claim Online submissions, please click [here](#).

Submit a Pharmacy Claim

[Submit Pharmacy Claim Online](#) ↗

Or you may print and complete a [Standard Pharmacy Claim Form \(PDF\)](#), then mail to:

OptumRx Manual Claims
P.O. Box 650334
Dallas, TX 75265-0335

Non-Discrimination Notice

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC 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: 1-866-213-3062 or TTY 711

If you believe that KPIC 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 with the KPIC Civil Rights Coordinator, 3701 Boardman-Canfield Rd Building B, Canfield, OH 44406 telephone number 1-866-213-3062. You can file a grievance by mail or phone. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you. 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>.

Consumer Assistance Tools

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your benefits, or you are required to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic): የሌሎችም ከፍተኛ ጠቅላይ ለርዳታ የማግኘት ሙብት አለዎት። ስለ ጥቅምተኛዎቻችሁ ጥያቄዎች ካሉዎት ወይም በተወሰነ ቀን እንዲያከናውኑ የሚጠበቅዎ ደርጊት ካለ፣ ስራዎን ወይም ክልልዎ ከተርጓሚ ጋር እንዲነጋገር በተሰጠዎ ስልክ ቁጥር ይደውሉ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن المزايا الخاصة بك أو قد طلب منك اتخاذ إجراء خلال تاريخ محدد، يرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Northern California Region.....	1-800-663-1771
Southern California Region.....	1-800-533-1833
Colorado Region.....	1-877-883-6698
Mid-Atlantic States Region.....	1-877-740-4117
Northwest Region.....	1-866-800-3402
Georgia Region.....	1-866-800-1486
TTY.....	711

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր նպաստների, կամ Դուք պարտադրված եք գործողություններ ձեռնարկել մինչև որոշակի ամսաթիվ, ապա զանգահարե՛ք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bàsòò - wùdù (Bassa): Ɔ m̀ò ni kpé bé m̀ ké gbo-krá-kpá dyé dé m̀ miòùn niin bídí-wùdù mú pidyi. Ɔ jù ké m̀ dyi dyi-diè-dè bé bédè bá kpána bé m̀ kò m̀ ké dyée jè dyi, m̀ò Ɔ jù ké wa dyi niin m̀ me nyu dè díé bé bó wé jèé d̀ò k̀òe ní, níí, m̀ me dá nòbá bé wa tòá bó ní bóqòò m̀ò bó ní gbèèò bíie, bé m̀ ké nyo-wuđuún-zà-nyò d̀ò gbo wùdù.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার সুবিধাসুগির সন্দর্ভে আপনার যদি কোল প্রশ্ন থাকে, অথবা একটি নির্দিষ্ট দিলের মধ্যে যদি আপনার কোল পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সঙ্গে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে কোল করুন।

Your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente Insurance Company provides certain administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan. • Kaiser Permanente Insurance Company (KPIC), Orway Building, One Kaiser Plaza, Oakland, CA 94612

Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo benepisyo o may mga butang nga nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的福利有任何疑問，或者您被要求在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chuukese): Mei wor omw pwuung omw kopwe neuneu aninis non kapasen fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw pekin insurance, are ika a men auhea omw kopwe fori pwan ekoch foror mei namot ngeni omw plan, ke tongeni kori ewe nampa ren omw state ika neni (asan) pwe eman chon awewe epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de vos avantages ou si vous devez prendre des mesure à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Leistungsanspruchs haben oder Sie bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઈ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને તમારા લાભો વિશે પ્રશ્નો હોય, અથવા કોઈ ચોક્કસ તારીખથી તમને પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પુરો પાડવામાં આવેલ નંબર પર કોલ કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan av sa a gen bagay ou sipoze fè avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

‘ōlelo Hawai‘i (Hawaiian): He pono a ua loa‘a no kekahi kōkua me kāu ‘ōlelo inā makemake a he manuahi no ho‘i. Inā he mau nīnau kāu e pili ana i kāu pono keu i ka polokalamu ola kino, a i ‘ole inā ke ha‘i nei iā‘oe e hana koke aku i kēia ma mua o kekahi lā i waiho ‘ia, e kelepona aku i ka helu i loa‘a nei no kāu moku‘āina a i ‘ole pana‘āina no ka wala‘au ‘ana me kekahi kanaka unuhi ‘ōlelo.

हिन्दी (Hindi): आपको बिना कोई कीमत चुकाए आपकी भाषा में मदद पाने का अधिकार है। यदि आप आपके लाभ के बारे में कोई सवाल पूछना चाहते हैं या आपको किसी निश्चित तारीख तक कोई कारवाई करने की आवश्यकता है, तो आप आपके राज्य या क्षेत्र के लिए दिये गए नंबर पर फोन करके किसी दुभाषिण से बात करें।

Hmoob (Hmong): Koj muaj cai tau txais kev pab txhais ua koj hom lus pub dawb. Yog koj muaj lus nug txog koj cov txiaj ntsig, lossis koj yuav tsum tau ua raws li hnuv hais tseg ntawd, hu rau tus nab npawb xvotooj ntawm lub xeev lossis hauv ib cheeb tsam uas tau muab rau koj mus tham nrog ib tug kws txhais lus.

Igbo (Igbo): ! nwere ikike inweta enyemaka n'asusu gi na akwughị ugwo o bula. O buru na ! nwere ajuju gbasara elele gi, ma o bu na achoro ka ! mee ihe tupu otu ubochi, kpo o nomba enyere maka steeti ma o bu mpaghara gi i ji kwukorita okwu n'etiti onye okpwa okwu.

Iloko (Ilocano): Adda dda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep kadagiti benepisioyo wenno, mangkalikagum kadakayo a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehiyon tapno makipatang ti maysa mangipatarus iti pagsasao.

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Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti le tue agevolazioni o se devi intervenire entro una data specifica, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご利用の言語で支援を受ける権利を保持しています。給付に関してご質問があるか、または、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីអត្ថប្រយោជន៍របស់លោកអ្នក ឬត្រូវបានតម្រូវឱ្យអ្នក ចាត់វិធានការត្រឹមត្រូវបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. 귀하의 보험 혜택이나 이 통지서의 요구대로 어느 날짜까지 조치를 취해야만 하는 경우, 제공된 귀하의 주 및 지역 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າ ທ່ານມີຄຳຖາມກ່ຽວກັບສິນປະໂຫຍດຂອງທ່ານ, ຫຼື ທ່ານຈຳເປັນຕ້ອງດຳເນີນການພາຍໃນອັນທີ່ຕ້ອງຈະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໂທໄວ້ສຳລັບລັດ ຫຼື ເຂດຂອງທ່ານເພື່ອຂໍລິມັດພາຍພາສາ.

Kajin Majōl (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjelōk wōṇāān. Ńe ewōr aṃ kajjitōk kōn jibañ ko aṃ, ak ñe kwoj aikuuj in ṃakūtūtūt ṃokta jān juon raan eo eṃōj an kallikkar, kaļok nōṃba eo ej leļok ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): Doo bik'é asinílaágo ata' hane' bee níká i' doolwoł. Bee naa áháyanígíí dóó bee níká aná'álwo'ígíí bina'ídiłkídgo, éi doodago náás yoolkáálgi hait'éegoda i' dííłíí nì' dì' nígo, bik'ehgo béésh bee hane'í naaltsoos bikáá'íjì' hodiłnih nitsaa hahoodzojì' éi doodago aadi nahós'a'di áko ata' halne'í bich'í' hadíidzih.

नेपाली (Nepali): तपाईंले कुनै खर्च बिना आफ्नो भाषामा सहायता पाउने अधिकार छ। यदि सुविधाहरूका बारेमा तपाईंको कुनै प्रश्नहरू भए, अथवा कुनै निर्धारित मिति भित्र तपाईंले कुनै कारवाही गर्न आवश्यक भए, कुनै दोभाषेसँग कुरा गर्न तपाईंको राज्य वा क्षेत्रका लागि उपलब्ध नम्बरमा फोन गर्नुहोस्।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee tajaajila keetii ilaalchisee gaaffii yoo qabaatte, yookaan yoo guyyaa murtaa'e irratti tarkaanfii akka fudhattu gaafatamte, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره مزایای خود سوالی داشته یا لازم است تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng kosoandi me pid kamwau pe kan, de anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr (insert number here) ohng owmi palien wehi pwe komwi en lokaiaiang owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre seus benefícios, ou caso seja necessário que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

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ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੇ ਫਾਇਦਿਆਂ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ.

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de beneficiile dumneavoastră sau vi se solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно ваших преимуществ либо необходимо выполнение каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua fua se fesoasoani i lou lava gagana. Afai e iai ni fesili e uiga i ou penefiti, pe e manaomia onae gaoioi a o le'i oo i se aso filifilia, vili le numera ua saunia atu mo lou setete po o vaipanoa e talanoa i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de sus beneficios o si se le solicita que tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong mga benepisyo o kinakailangan mong magsagawa ng aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับสิทธิประโยชน์ของท่าน หรือท่านจำเป็นต้องดำเนินการภายในวันที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'i ai ho totonu ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i 'o fekau'aki mo ho ngaahi penefiti, pe ko ha me'a na'e fiema'u ke fai ki ha 'aho na'e tukupau atu ke fakahoko ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua ke talanoa mo ha fakatonulea.

Українська (Ukrainian): У Вас є право на отримання допомоги на Вашій рідній мові безкоштовно. Якщо Ви маєте питання стосовно Ваших переваг, чи якщо Вам необхідно здійснити певну дію до конкретної дати, подзвоніть по номеру телефону, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اردو (Urdu): آپ کو کوئی بھی قیمت ادا کرنے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنے فوائد کے متعلق کوئی سوالات ہیں، یا آپ کو ایک مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہے تو، کسی مترجم سے بت چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về các lợi ích của mình, hoặc quý vị được yêu cầu thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti gba irànwọ́ ní èdè rẹ̀ lẹ́fẹ́fẹ́. Tí o bá ní ibéèrè nipa àwọn ànfàní rẹ̀ tàbí o ní láti gbé igbésẹ̀ kan ní ojọ kan pátọ̀, pe nọmbà tí a pèsè fún ipinlẹ̀ rẹ̀ tàbí agbègbè láti bá ògbùfọ̀ kan sọrọ̀.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network and/or your plan does not cover out-of-network Services.

“Out-of-network” means providers and facilities that haven't signed a contract with your health plan to provide Services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a Service. This is called “**balance billing**.” This amount is likely more than your in-network costs for the same Service and might not count toward your plan's deductible or annual out-of-pocket limit. Your health plan coverage may not cover out-of-network Services when you agree (consent) to receive Services from the out-of-network providers.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or Service. Providers and facilities are not balance billing you when they seek to collect cost sharing or another amount that you agreed to pay or are required to pay under your plan for the Services that they provided.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency Services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency Services. This includes Services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization Services.

Certain Services at an in-network hospital or ambulatory surgical center

When you get Services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology,

assistant surgeon, hospitalist, or intensivist Services, or when an in-network provider is not available. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of Services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency Services without requiring you to get approval for Services in advance (also known as "prior authorization").
 - Cover emergency Services by out-of-network providers and facilities.
 - Base what you owe the provider or facility (your cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency Services or non-emergency Services provided by certain out-of-network providers at an in-network facility toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed by a provider or facility, contact the federal government at: **1-800-985-3059**.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.