



**COVENTRY HEALTH CARE OF GEORGIA, INC.**

**HEALTH MAINTENANCE ORGANIZATION**

**("HMO")**

**CERTIFICATE OF COVERAGE**



Dear New Member:

Welcome to Coventry Health Care of Georgia! We are extremely pleased that you have enrolled in our health plan and look forward to serving you.

Coventry is a subsidiary of Coventry Health Care, Inc., a Fortune 500 company operating health plans, insurance companies, network rental and workers' compensation services companies in all 50 states and Puerto Rico. We are one of the country's largest managed health care companies providing a full range of risk and fee-based health care products and services.

Coventry Health Care's benefit plans emphasize wellness and preventive care. You will find that our strong network of area physicians, hospitals, and other providers offers a broad range of services to meet your medical needs.

As a Coventry Health Care member, it is important that you understand the way your health plan operates. This Certificate of Coverage is an important legal document, and contains the information you need to know about your coverage with us and how to get the care you need. Please keep it in a safe place where you can refer to it as needed.

Please take a few minutes to read these materials and to make your covered family members aware of the provisions of your coverage. Our Customer Services Department is available to answer any questions you may have about your coverage. You can reach them at (800) 395-2545 Monday through Friday, 7:00 a.m. to 6:00 p.m. ET. You may also access your benefit information 24 hours a day, seven days a week by registering and logging in at [www.chcga.com](http://www.chcga.com).

We look forward to serving you and your family.

Sincerely,

A handwritten signature in black ink, appearing to read "T. Davis", is written over a horizontal line.

Thomas Davis  
Chief Executive Officer  
Coventry Health Care of Georgia, Inc.



## Coventry Health Care of Georgia, Inc. Certificate of Coverage

The Agreement between Coventry Health Care of Georgia, Inc. (hereafter called the "Health Plan", "CHC", "We", "Us", or "Our") and You is made up of the following documents:

- Certificate of Coverage and any amendments;
- Enrollment Applications/Health Statements;
- Schedule of Benefits;
- Applicable Riders; and
- Group Contract.

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to this Agreement unless approved in writing by an officer of the Health Plan, and the resulting waiver, change, or amendment is attached to the Agreement. This Agreement begins on the Group Effective Date defined in the Group Contract. It continues, until replaced or terminated, while its conditions are met. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the rules and regulations of the Health Plan. By paying premiums or having premiums paid on Your behalf, You accept the provisions of this Agreement.

**THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY.** Many of the provisions of this Agreement are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement have special meanings. These words will appear capitalized and are defined for You. By using these definitions, You will have a clearer understanding of Your Coverage.

From time to time, the Agreement may be amended. When this occurs, We will provide an Amendment or new Certificate of Coverage to You for this Agreement. You should keep this document in a safe place for Your future reference.

**COVENTRY HEALTH CARE OF GEORGIA, INC.  
1100 CIRCLE 75 PARKWAY  
SUITE 1400  
ATLANTA, GA 30339  
(800) 395-2545**

**Informacion en Espanol esta disponible a su pedido. Llame nuestro Servicio al Cliente linea de traduccion al 1-800-395-2545.**

**Information in Spanish available upon request. Please call our Customer Service translation line at 1-800-395-2545.**

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## **SECTION 1**

### **USING YOUR BENEFITS**

**1.1 Membership Identification (ID) Card.** Every Health Plan Member receives a membership ID card. Please carry Your Member ID card with You at all times, and present it before health care services are rendered. If Your Member ID card is missing, lost, or stolen, contact Our Customer Service Department at (800) 395-2545 or visit Our website at [www.chcga.com](http://www.chcga.com) to order a replacement.

**1.2 Your Primary Care Physician (PCP).** Although You are not required to select a PCP under Your Plan, We encourage You to select a PCP from the Directory of Health Care Providers. **The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. This may include preventive health services, consultation with Specialists and other Providers, Emergency Services, and Urgent Care.**

You can select a PCP from one of the following specialties: Family Practice, Internal Medicine, General Practice, or Pediatrics. You may choose one PCP the entire family, or each Dependent may select a different PCP. To locate the most current Directory of Health Care Providers, please visit Our website at [www.chcga.com](http://www.chcga.com). Our online provider directory is updated at least monthly.

Should You wish to change Your PCP, You must contact Our Customer Service Department at (800) 395-2545. You may also visit Our website at [www.chcga.com](http://www.chcga.com) to make this change.

**1.3 Participating Providers.** Your Plan allows direct access to Participating Specialists. This means that You do not need a PCP referral to receive care from a Participating Specialist. As long as the Specialist participates in our provider network, you may make an appointment and visit that Specialist without checking with Your PCP first.

Female Members age thirteen (13) and older may select a Participating OB-GYN Physician and seek primary care services directly from their OB-GYN Physician if they wish (no PCP selection or referral is needed).

Please remember that all care must be obtained from a Participating Provider unless specifically authorized by Us, in accordance with CHC policies and procedures. Services not available from a Participating Provider will require prior approval by the Health Plan. If Your Provider feels that You need to see a Non-Participating Provider, then Your Provider must call Us or submit the supporting clinical information to Us in writing. The Health Plan will review the request and You and Your Physician will be notified of the decision.

**It is Your responsibility as a Member to ensure all services are rendered by a Participating Provider. Members will be fully liable for services rendered by non-Participating Providers.**

**Please visit Our website at [www.chcga.com](http://www.chcga.com) to find the most current list of Participating Providers.**

**1.4 Prior Authorizations.** Hospitalizations and certain procedures may require a Prior Authorization. Refer to the Schedule of Covered Services in Section 5 to find out which Covered Services require Prior Authorization. Please note that Prior Authorization requirements may change from time to time. Because You have an HMO Plan, Your Participating Provider is responsible for obtaining the Prior Authorization from Us on Your behalf. When We approve or deny a Prior Authorization request, We send a notification letter to You and You Provider.

- 1.5 Access to Services.** We make every effort to ensure that Your access to Covered Services is quick and easy and the services are reasonably available. If You wish to see a particular Provider who is not accepting new patients or is no longer participating in Our network, please call Our Customer Service Department at (800) 395-2545. We can help You find another Participating Provider that meets Your needs. You may also nominate Your Non-Participating Provider to become a Participating Provider with CHC, or nominate Your Non-Participating Provider under the Consumer Choice Option. Please call Our Customer Service Department for more information.

Continuity of care is especially important to Us. If Your Participating Provider unexpectedly stops participating with Us while You are in the middle of treatment, please call Us so We can help You continue treatment with another Participating Provider. In the following situations, We will allow You to continue Your treatment with Your Non-Participating Provider:

- a. If You are suffering from terminal or chronic illness or are an inpatient, We will continue to pay for Covered Services You receive from Your Non-Participating Provider for sixty (60) days following the Provider's termination from Our network; and
- b. If You are pregnant, We will continue to pay for Covered Services rendered by Your Non-Participating Provider through delivery and including six (6) weeks of post-delivery care.

We will provide Medically Necessary health care services twenty-four (24) hours a day, seven (7) days a week.

- 1.6 Copayments, Coinsurance, Deductibles, and Carryover.** Your Copayment, Coinsurance and Deductible amounts are listed in Your Schedule of Benefits. You are responsible for paying Copayments to Your Provider at the time of service. Coinsurance and Deductible amounts, based on the Health Plan's reimbursement to the Provider, may be due to the Provider before or at the time of service. The typical order of payment of these amounts on claims is as follows: Copayments are applied first, then Deductibles and finally Coinsurance. However, please be aware that Your specific Plan may have different rules. Please see Your Schedule of Benefits for the specific rules of Your Plan.

**Please Note: The applicable Copayment, Deductible and/or Coinsurance amounts must be paid for every Physician office visit.**

**Individual Deductible.** Before the Health Plan will pay for Your Covered Services, You must satisfy Your individual annual Deductible. You satisfy the annual Deductible by directly paying Your Provider for Covered Services. After the individual annual Deductible is satisfied, the Health Plan will pay for Your Covered Services, minus any applicable Copayments or Coinsurance.

**Family Deductible.** If your family includes two (2) or three (3) individuals, each family Member is required to meet one hundred percent (100%) of his/her individual annual Deductible (as noted above) before the Health Plan will pay for Your family's Covered Services, minus any applicable Copayments or Coinsurance. However, if Your family is made up of four (4) or more individuals, the family has satisfied the annual Deductible when:

- a. three (3) family Members have each satisfied their individual annual Deductibles; or
- b. four (4) or more family Members have cumulatively satisfied an amount equal to three (3) individual annual Deductibles.

Please be aware that payments You make for non-Covered Services will not count toward the satisfaction of Your individual or family annual Deductible.

**Carryover.** If You pay any portion of Your annual Deductible (as noted above) during the last three (3) months of the Benefit Year, that paid amount will carryover and be applied toward the satisfaction of Your new annual Deductible in the following Benefit Year. For example: Your Benefit Year begins on October 1 of each year, and Your Deductible is \$1,000. During the months of July, August and September of Benefit Year 1, You pay \$750 towards Your Deductible. On October 1, the first day of Benefit Year 2, We will “carryover” and apply the \$750 towards Your Deductible for Benefit Year 2, and You will owe only \$250 to fully satisfy Your annual Deductible for the remainder of Benefit Year 2.

**For Members enrolled in a Qualified High Deductible Health Plan with a health savings account (HSA):** Please be aware that Deductible carryover may disqualify Your Plan. Under Georgia law 33-6-5(14), amended in 2005, Qualified High Deductible Health Plans purchased in connection with a tax-advantaged program such as an HSA are exempted from the carryover deductible requirement, therefore the example outlined above does not apply to Your Plan. Please visit the Internal Revenue Service website, or consult with Your financial advisor for more information.

- 1.7 **Out-of-Pocket Maximum (“OOP Max”).** Your Out-of-Pocket Maximum (OOP Max) amounts are set forth in Your Schedule of Benefits. The individual OOP Max is the total amount You must pay out of Your pocket annually for specified Covered Services. The family OOP Max is the total amount family Members must pay annually for specified Covered Services.

Most Coinsurance amounts are applied to the annual OOP OP Max.  
 Copayments and Deductible amounts typically are *not* applied to the annual OOP Max.  
**Please see Your Schedule of Benefits for the specific rules concerning the amounts that apply to the annual OOP Max.**

If You satisfy the annual OOP Max, then You pay nothing more for Covered Services for the remainder of the Benefit Year, except for Copayments.

[Please be aware that there may be separate Out-of-Pocket Maximum amounts for Covered Services provided under Riders to Your Health Plan. Please refer to the specific Rider for more information.]

- 1.8 **Maximum Lifetime Benefit.** The maximum lifetime benefit payable per Member, if applicable, is listed in Your Schedule of Benefits.

- 1.9 **Submission of Bills and Claims.** Participating Providers bill the Health Plan directly for all Covered Services. If You receive a bill or claim from a Provider, please send it to the Health Plan at:

Coventry Health Care of Georgia, Inc.  
 P.O. Box 7711  
 London, KY 40742  
 ATTN: Claims Department

Except in the absence of the Member’s legal capacity, bills or claims will not be accepted from Members later than one (1) year after the date of service.

- 1.10 **How to Contact the Health Plan.** Whenever You have a question or concern, please call Our Customer Service Department at the telephone number on Your Member ID card, or visit Our website at [www.chcga.com](http://www.chcga.com). Our contact information is listed below.

<b>For Customer Service Department and To Submit Claims</b>	
<b>Hours</b>	Monday-Friday: 7:00 am to 6:00 pm EST

<b>Toll Free Telephone Number</b>	(800) 395-2545
<b>Address:</b>	Coventry Health Care of Georgia, Inc. P.O. Box 7711 London, KY 40742

<b>To Request a Review of Denied Claims</b>	
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<b>Hours</b>	Monday-Friday: 7:00 am to 6:00 pm EST
<b>Toll Free Telephone Number</b>	(800) 395-2545
<b>Address:</b>	Coventry Health Care of Georgia, Inc. 1100 Circle 75 Parkway, Suite 1400 Atlanta, GA 30339 Attn: Appeals Department

<b>To Appeal a Noncertification of Services</b>	
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<b>Hours</b>	Monday-Friday: 7:00 am to 6:00 pm EST
<b>Toll Free Telephone Number</b>	(800) 395-2545
<b>Address:</b>	Coventry Health Care of Georgia, Inc. 1100 Circle 75 Parkway, Suite 1400 Atlanta, GA 30339 Attn: Appeals Department

<b>To Register a Complaint</b>	
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<b>Hours</b>	Monday-Friday: 7:00 am to 6:00 pm EST
<b>Toll Free Telephone Number</b>	(800) 395-2545
<b>Address:</b>	Coventry Health Care of Georgia, Inc. 1100 Circle 75 Parkway, Suite 1400 Atlanta, GA 30339 Attn: Quality Department

- 1.11 Verification of Benefits.** When We provide information about which health care services are covered under Your Plan, that information is referred to as “verification of benefits.” When You or Your Provider calls Our Customer Service Department at (800) 395-2545 during regular business hours to request verification of benefits, a Health Plan representative will be immediately available to provide assistance.

If the health care services are verified as a covered benefit, the Customer Service representative will advise whether Prior Authorization is required. The telephone number Your Provider must call to request such Prior Authorization is located on the back of Your Member ID Card.

**Please be aware that verification of benefits is not a guarantee of payment for those services.**

## **SECTION 2**

### **ENROLLMENT, ELIGIBILITY AND EFFECTIVE DATES**

**2.1 Eligibility.**

**2.1.1 Subscriber Eligibility.** To be eligible to be enrolled as a Subscriber, You must:

- a. Live or work in the Service Area; and
- b. Be an employee of the Group; and

- c. Be eligible to participate equally in any alternate health benefits plan offered by the Group by virtue of Your own status with the Group, and not by virtue of dependency; and
- d. Meet any eligibility criteria specified by the Group and approved by CHC; and
- e. Complete and submit to CHC such applications or forms that CHC may reasonably request.

**2.1.2 Dependent Eligibility.** To be eligible to be enrolled as a Dependent, an individual must be the lawful spouse of the Subscriber, or be an unmarried child of the Subscriber or the Subscriber's spouse including:

- a. Children under age nineteen (19) who are either the birth children of the Subscriber or the Subscriber's spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's spouse;
- b. Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is required to provide health care Coverage pursuant to Qualified Medical Child Support Order;
- c. Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian;
- d. Children nineteen (19) or older if the following criteria is met:
  - the child is the birth or adopted child of the Subscriber or the Subscriber's spouse; or
  - the Subscriber or Subscriber's spouse is the court-appointed legal guardian or is required to provide health care coverage under a Qualified Medical Child Support Order, and
  - The child is mentally or physically incapable of earning a living as determined by the Georgia Department of Human Resources, and is chiefly dependent upon the Subscriber for support and maintenance, provided that: the onset of such incapacity occurred before age nineteen (19).
  - Proof of incapacity and dependency must be furnished to CHC within thirty-one (31) days of the child attaining age nineteen (19) and subsequently thereafter, but not more frequently than annually after the two (2) year period following the child attaining age nineteen (19).
- e. Children under the age of twenty-six (26) who are either the birth or adopted children of the Member and are enrolled for five (5) calendar months or more in each calendar year as a full-time student at an accredited post-secondary educational institution of higher learning, provided that the Subscriber provides documentation of such attendance to CHC upon request. Coverage ends the last day of the month in which the Dependent attains the age of twenty-six (26) or is no longer enrolled in school on a full-time basis. If the child would have been eligible to enroll in such educational institution but was prevented from being enrolled due to illness or injury, then the child shall remain eligible in accordance with the terms of this section, provided that upon the end of such illness or injury the child must enroll as a full-time student in the educational institution or lose eligibility. The Subscriber must provide evidence of illness or injury to CHC upon request.

**2.2 Change of Group's Eligibility Rules.** In order to be eligible for Coverage under this Health

Plan, You must also meet specific Group eligibility requirements as defined in the Group Contract. So long as this Agreement is in effect, any change in the Group's eligibility requirements must be approved in advance by CHC and evidenced in the Group Contract.

### **2.3 Persons Not Eligible to Enroll.**

- a. A person who fails to meet the eligibility requirements specified in this Agreement shall not be eligible to enroll or continue enrollment with CHC for Coverage under this Agreement.
- b. Late enrollees are not eligible to enroll except during the next Group Enrollment Period. A late enrollee is an individual who fails to enroll for Coverage during the required thirty-one (31) day period when they first become eligible for Coverage.
- c. A child born to or adopted by a Dependent child shall not be eligible to enroll.

### **2.4 Enrollment and Effective Dates.**

**2.4.1 Group Enrollment Period:** All eligible employees of a Group and their eligible Dependents may enroll with CHC for Coverage under this Agreement during the Group Enrollment Period by submitting an Enrollment Application to CHC. Such employees and Dependents shall be covered under this Agreement as of the Member Effective Date, a date mutually agreed to by CHC and the Group.

**2.4.2 Newly Hired Employees:** All newly hired employees and their eligible Dependents may enroll with CHC for Coverage under this Agreement by submitting an Enrollment Application to CHC within thirty-one (31) days after becoming eligible. Such employees and Dependents shall be covered under this Agreement as of the Member Effective Date, a date mutually agreed to by CHC and the Group. If the employee fails to submit the Enrollment Application within thirty-one (31) days after becoming eligible, the employee and Dependents are not eligible to enroll until the next Group Enrollment Period, unless there is a special enrollment qualifying event as described in Section 2.5.

**2.4.3 Transferred Employees:** Any employees and their eligible Dependents who transfer into the CHC Service Area may enroll with CHC for Coverage under this Agreement by submitting an Enrollment Application to CHC within thirty-one (31) days after becoming eligible. Such employees and Dependents shall be covered under this Agreement as of the Member Effective Date, a date mutually agreed to by CHC and the Group. If the employee fails to submit the Enrollment Application within thirty-one (31) days after becoming eligible, the employee and Dependents are not eligible to enroll until the next Group Enrollment Period, unless there is a special enrollment qualifying event as described in Section 2.5.

**2.4.4 Special Enrollees:** Special enrollees and their eligible Dependents may enroll with CHC for Coverage under this Agreement as described in Section 2.5.

**2.4.5 Newborns:** A newborn child is automatically covered for the treatment of injury or sickness, including medically diagnosed congenital defects, birth abnormalities, premature birth and routine nursery care, for the first thirty-one (31) days from the date of birth. For Coverage to continue beyond the first thirty-one (31) days, application to add the child as a Dependent must be received within thirty-one (31) days from the date of birth. If no additional premium is required to enroll a Dependent under the family Coverage, then Coverage for the Dependent child is effective from the date of the birth, however, We should be given notice within thirty-one (31) days of the birth to add the Dependent child.

- 2.4.6** Adopted Children: An adopted child is automatically covered for the treatment of injury or sickness, including medically diagnosed congenital defects, birth abnormalities, premature birth and routine nursery care, for the first thirty-one (31) days from the date of the placement for adoption or the final decree of adoption, whichever is earlier. For Coverage to continue beyond the first thirty-one (31) days, application to add the child as a Dependent must be received within thirty-one (31) days from the earlier of the date of placement or adoption. If no additional premium is required to enroll a Dependent under the family Coverage, then Coverage for the Dependent child is effective from the date of placement or adoption, however, We should be given notice within thirty-one (31) days of the placement or adoption to add the Dependent child.
- 2.4.7** Qualified Medical Child Support Orders: Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order shall be covered as of the date specified in the order. If no date is specified in the order, Coverage shall be effective as of the date the order is issued by the court.
- 2.4.8** Eligible employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under this Agreement are not eligible to enroll until the next Group Enrollment Period, unless they are eligible to enroll under a special enrollment qualifying event as described in Section 2.5.
- 2.4.9** CHC will furnish to the Group, for delivery to each Member, an individual certificate which summarizes the essential features of the Coverage and to whom benefits are payable.

## **2.5 Special Enrollment and Effective Dates.**

- 2.5.1 Special Enrollment Qualifying Events.** A “special enrollment qualifying event” is any of the following events:
- Marriage;
  - Birth of a child;
  - Adoption of a child (including placement for adoption); and
  - Loss of other coverage, including COBRA.
- 2.5.2 Special Enrollment Due to Loss of Other Coverage.** Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Health Plan if the employee waived Coverage under this Health Plan at the time Coverage was most recently made available because the employee or Dependent had other coverage at the time that this Health Plan Coverage was offered, and the employee’s or Dependent’s other Coverage was:
- a. COBRA continuation Coverage that has since been exhausted; or
  - b. If not COBRA continuation Coverage, such other coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term “loss of eligibility for such Coverage” includes (1) a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; or (2) in the case of coverage offered through an HMO, loss of coverage because the employee or Dependent no longer lives or works in the HMO’s service area. This term does not include loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause (i.e., fraud or intentional misrepresentation); or
  - c. A situation in which the employee or Dependent incurs a claim that would meet

or exceed a lifetime limit on all benefits offered under the other coverage.

- d. Required Length of Special Enrollment: An employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date that the other coverage was lost, or in the case where the employee or Dependent has exceeded a lifetime limit on all benefits offered under the other coverage, no later than thirty (30) days after a claim is first denied due to the operation of a lifetime limit on all benefits.
- e. Effective Date of Coverage: If the employee or Dependent enrolls within the thirty-one (31) day period, Coverage under the Health Plan will become effective no later than the first (1<sup>st</sup>) day of the first (1<sup>st</sup>) calendar month after the date the completed request for special enrollment is received.

**2.5.3 Special Enrollment Due to New Dependent Eligibility.** Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Health Plan if the employee has acquired a Dependent through marriage, birth, adoption or placement for adoption.

- a. Non-participating Employee: An employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).
- b. Non-participating Spouse: Your spouse may enroll at the time of marriage to You, or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).
- c. New Dependents of Covered Employee: A child who becomes a Dependent of a covered employee as a result of marriage, birth, adoption or placement for adoption may enroll at that time.
- d. New Dependents of Non-enrolled Employee: A child who becomes a Dependent of a non-enrolled employee as a result of marriage, birth, adoption or placement for adoption may enroll at that time but only if the non-enrolled employee is eligible for enrollment and enrolls at the same time.
- e. Required Length of Special Enrollment: An employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date of marriage, birth, adoption or placement for adoption.
- f. Effective Date of Coverage: Coverage shall become effective:
  - (i) In the case of marriage, the date of marriage. A completed Enrollment Application must be received by the Health Plan within thirty-one (31) days of the date of marriage.
  - (ii) In the case of a Dependent's birth, the date of such birth.
  - (iii) In the case of a Dependent's adoption, the earlier of the date of placement for adoption or final decree of adoption.

**2.6 Notification of Change in Status.** You must notify the Health Plan of any changes in Your status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on an Enrollment Application to the Health Plan. Events qualifying as a change in status include, but are not limited to, employment, divorce, marriage, dependency status, Medicare eligibility or Coverage by another payer. The Health Plan

should be notified within a reasonable time of the death of any Member. You should also notify the Health Plan within thirty-one (31) days of changes of address for You or Your Dependents.

- 2.7 Inpatient on the Member Effective Date.** Regardless of whether a person is confined as an inpatient in any Hospital, Skilled Nursing Facility or Hospice on the date such person is to become a Member, the person shall become a Member on such Member Effective Date.

### **SECTION 3**

#### **TERMINATION OF COVERAGE**

- 3.1 Termination of Member Coverage.** Your Coverage shall terminate upon the occurrence of any one of the following events:

**3.1.1** At least sixty (60) days notice of termination of Your Coverage will be provided in person or by U.S. mail if:

- a. Your Group policyholder has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the Group health insurance policy or contract.
- b. Your Group policyholder has violated CHC's minimum employer contribution or Group participation rules.
- c. You no longer live in the Service Area, unless You agree in writing to return to the Service Area to receive Covered Services (except for Emergency Services).
- d. You no longer meet the eligibility requirements set forth in this Agreement.

**3.1.2.** Due to the nonpayment of premiums.

**3.1.3** Upon the termination or non-renewal of the Group Contract by the Group.

**3.1.4.** Upon termination, cancellation or non-renewal by Us of all Coverage under a particular policy form which affects You, provided that:

- a. CHC provides at least ninety (90) days notice prior to the termination of the policy form to all policyholders and certificate holders;
- b. For a policy form used by small employers, We offer to such small employer policyholders the option to purchase all other group policies from the insurer currently being offered to or renewed by small employers in this State for which the small employer policyholders would otherwise be eligible;
- c. For a policy form used by large employers, We offer to such large employer policyholders the option to purchase any other group policy from the insurer currently being offered to or renewed by a large employer in Georgia; and
- d. We act uniformly without regard to the claims experience of any or all policyholders, covered employers, or any health status related factor relating to any enrollees or other eligibles covered by or eligible for Coverage under the policy.

**3.1.5.** If CHC discontinues offering and terminates, cancels, or does not renew all Coverage in either the small employer market or the large employer market, or both, provided that:

- a. We provide at least one hundred eighty (180) days notice prior to the discontinuance or non-renewal of a policy or contract to all policyholders and certificate holders;
- b. We provide at least one hundred eighty (180) days notice to the Commissioner prior to the earliest date of termination or non-renewal related to the discontinuation in the market and indicates in such notice the date described in subparagraph (iii) below; and
- c. We do not issue Coverage in such market for five (5) years beginning with the date of the last health insurance policy or contract in that market not renewed.

**3.1.6.** If Your employer ceases membership in an association through which health insurance coverage is issued, provided that We were still issuing coverage through that association, or the association was still making such coverage available, and the coverage cancellation or non-renewal is uniform without regard to any health status related factor relating to any insured. If the association ceases to make coverage available under any health insurance policy or contract, or ceases to exist, employers covered under such association policies shall be considered policyholders and shall be guaranteed renewability by the insurer.

**3.1.7.** Immediate termination of Your Coverage will occur if You participate in fraudulent acts, including but not limited to:

- a. Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts, including using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all of Subscriber's Dependents will be terminated.
- b. Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and all of Subscriber's Dependents will be terminated.
- c. Knowingly misrepresenting or giving false information on any Enrollment Application form which is material to CHC's acceptance of such application.

**3.1.8** Once You have been accepted for Coverage, Your Coverage cannot be terminated by Us due solely to Your individual claims experience.

## **3.2 Effect of Termination.**

**3.2.1** If Your Coverage under this Agreement is terminated under Section 3.1, all rights to receive Covered Services shall cease as of the date of termination, except that if You are an inpatient in a Hospital, Skilled Nursing Facility or Hospice facility on the date of termination You shall continue to be covered under this Agreement until the date of discharge. However, if You are totally disabled on the date Your Coverage is terminated under Section 3.1, Coverage will continue until the earlier of the following: (1) twelve (12) months; or (2) the date You are no longer totally disabled; provided, however, that any continuing Coverage shall only be for the ailment or injury which caused the total disability.

- 3.2.2** Identification cards are the property of CHC and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.
- 3.2.3** Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under CHC's appeal and complaint procedures. CHC may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

**3.3 Certificates of Creditable Coverage.** At the time Coverage terminates, or at the time You meet or exceed a lifetime limit on all benefits offered under the Coverage, You are entitled to receive a certificate of creditable coverage verifying the type of Coverage, the date of any waiting periods, and the date any creditable coverage began and ended.

Certificates of creditable coverage shall be sent:

- a. Automatically upon a loss of Coverage for any reason under a plan, including due to a COBRA qualifying event (as described in Section 4);
- b. Automatically upon loss of COBRA Coverage;
- c. At any time upon an individual's request within twenty-four (24) months after plan Coverage ends; or
- d. When an individual exceeds a lifetime limit on all benefits offered under the plan.

## **SECTION 4**

### **CONTINUATION OF COVERAGE**

#### **4.1 Continuing Group Coverage Under Federal Law.**

- 4.1.1** Under federal law, an employer who has twenty (20) or more employees is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA requires an employer to offer to Subscribers and Dependents the option to continue the Group Coverage for up to eighteen (18) months for one of the following qualifying events:
- a. the Subscriber's employment is terminated for any reason other than gross misconduct;
  - b. reduction in the Subscriber's scheduled work hours (e.g., change from full-time to part-time, lay off, leave of absence, etc.); or
  - c. the Subscriber's notification to the employer of the intent not to return to work, either during or after a Family Medical Leave Act approved leave.
- 4.1.2** If the Social Security Administration determines that the Subscriber was disabled during the first sixty (60) days of COBRA Coverage, Coverage for the Subscriber and Dependents may be continued for up to twenty-nine (29) months.
- 4.1.3** Coverage for Dependents may be continued for up to thirty-six (36) months for the following qualifying events:
- a. divorce;

- b. legal separation;
- c. attainment of the limiting age;
- d. the Subscriber's death; or
- e. the Subscriber becomes eligible for Medicare.

There are additional COBRA provisions that address the issue of Group bankruptcy.

**4.1.4** You must notify the Group's designated plan administrator within sixty (60) days of Your divorce, legal separation or loss of eligibility as a Dependent. Continuation must be elected by the later of sixty (60) days after the occurrence of Your qualifying event or sixty (60) days after the date You receive notification from the Group's designated administrator. The Group may require You to pay the full cost of the COBRA Coverage. The premium may not exceed 102% of the premium for similarly covered employees. A Member whose Coverage was terminated due to a qualifying event must pay the initial premium due to the Group's designated plan administrator on, or no later than, the forty-fifth (45<sup>th</sup>) day after electing COBRA continuation.

**4.1.5** COBRA Coverage ends when:

- a. the maximum continuation period ends;
- b. the Group ceases to provide any group health plan for any employee;
- c. the required premium is not paid when due;
- d. coverage begins under another group health plan that does not include a pre-existing condition clause; or
- e. the Member is eligible for coverage under Medicare.

**4.1.6** This explanation is not a legal opinion. It is provided to You as a courtesy, and is merely a general summary of Your continuation of Coverage rights under COBRA. It is important to note that the Internal Revenue Service may change or amend COBRA from time-to-time.

Please be aware that Your Group is responsible for complying with and administering COBRA Coverage. When You are hired, Your Group is responsible for informing You of the availability of COBRA Coverage. If Your Coverage under this Plan is terminated, Your Group is responsible for notifying You of Your eligibility for COBRA Coverage. Your Group is also responsible for notifying You if You are no longer eligible for COBRA Coverage. You should direct any questions about COBRA to Your Group.

## **4.2 Continuing Group Coverage Under Georgia Law (State Continuation Coverage).**

**4.2.1** Under Georgia law, You and/or Your Dependents are entitled to state continuation Coverage if:

- a. Your employment with the Group is terminated for any reason other than for cause;

- b. You have been continuously covered under this Health Plan or any preceding health plan for at least six (6) months immediately prior to termination;
- c. You are not enrolled in another group plan or Medicare; and
- d. You pay all required premiums, which is the same premium rate charged for similarly covered Subscribers.

**4.2.2** State continuation Coverage begins on the day of the month after Your termination date, and continues through the rest of the month plus three (3) additional months. At the end of the state continuation Coverage period, You have the right to elect conversion Coverage as described in Section 4.3.

**4.2.3** To elect state continuation Coverage, You must notify the Group of Your election within thirty (30) days following Your termination date.

**4.2.4** You are not entitled to state continuation Coverage if:

- a. termination of Coverage occurred because Your employment was terminated for cause;
- b. termination of Coverage occurred because You failed to pay any required premium contribution;
- c. Your discontinued Coverage is immediately replaced by similar group coverage (unless You were declined coverage under the replacement group coverage);
- d. Coverage was terminated for the entire class of employees to which You belong;
- e. the Group terminated Coverage for all employees; or
- f. the Group offers You COBRA Coverage as described under Section 4.1.

**4.3 Individual Conversion Coverage.** If Your Coverage is terminated and You are a “qualifying eligible individual” and/or “group member” as defined below, You and Your covered Dependents may enroll in a CHC conversion plan. We offer the conversion plans that are required to be offered by the Georgia Department of Insurance plans. Other conversion plan options may also be available.

**4.3.1 Qualifying Eligible Individuals.** A “qualifying eligible individual” is a Georgia resident who meets all of the following criteria:

- a. You have at least eighteen (18) months of creditable coverage;
- b. You are not eligible for coverage under any of the following:
  - Medicare;
  - Medicaid; or
  - Any group health plan, COBRA or state continuation coverage.
- c. Your Coverage under this Health Plan, COBRA or state continuation coverage was not terminated for fraud or failure to pay a required premium.
- d. You are not covered under any other group or individual creditable coverage.

**4.3.2 Group Members.** You are a “group member” if You have been covered under this

Health Plan for at least six (6) months.

**4.3.3 How To Enroll in Conversion Coverage.** To enroll in a Coventry conversion plan, You must submit an Enrollment Application and premium payment to Us within sixty-three (63) days of the date:

- a. Your Coverage under this Health Plan was terminated; or
- b. Your COBRA or state continuation Coverage was terminated, as applicable.

Please call Our Enrollment Department at 1-866-497-2473 for information on conversion plan enrollment, benefits and premium rates.

## **SECTION 5 COVERED SERVICES**

**5.1 Schedule of Covered Services.** CHC is a health maintenance organization (HMO), which is a type of managed care organization that provides health benefits coverage . We contract with Hospitals, Physicians and other Providers to provide health care services to Our Members. These contracted Hospitals, Physicians and Providers become part of Our HMO network. As a Member of Our Health Plan, You must receive Your medical treatment from Physicians and facilities within Our HMO network.

As an HMO, one of Our goals is to reduce health care costs by focusing on preventive care, and implementing Our utilization management program to help control costs. That is why some of Your Covered Services require Prior Authorization.

The following Schedule of Covered Services lists the health care services and supplies covered under Your Health Plan.

Please note that the Health Plan covers only those health care services and supplies that are:

- (1) deemed Medically Necessary by the Health Plan;
- (2) provided by a Participating Provider; and
- (3) not excluded under the exclusions and limitations set forth in Section 6.

<b>SCHEDULE OF COVERED SERVICES</b> <b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE</b> <b>MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS,</b> <b>AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Allergy</b>	Covered Service for:  Testing, diagnosis, treatment, allergy serum, and the administration of injections.	No Prior Authorization required.
<b>Ambulance</b>	Covered Service for:  Ground ambulance to Hospital when ambulance travel is determined to be Medically Necessary.  Air ambulance when determined to be an emergency by the Health Plan.	Prior Authorization is required unless emergent in nature.

<p align="center"><b>SCHEDULE OF COVERED SERVICES</b>  <b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE</b>  <b>MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS,</b>  <b>AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b></p>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Bone Density Testing</b>	Covered Service for the prevention, diagnosis and treatment of osteoporosis.	No Prior Authorization required.
<b>Breast Reconstruction</b>	<p>Covered Service when consistent with the federal Women’s Health and Cancer Rights Act of 1998.</p> <p>If You have a mastectomy and elect reconstructive surgery in connection with the mastectomy, Coverage will be provided for:</p> <ul style="list-style-type: none"> <li>• Reconstruction of the breast on which the mastectomy was performed;</li> <li>• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and</li> <li>• Prostheses and physical complications of mastectomy, including lymphedema.</li> </ul> <p>Coverage will be provided in a manner determined in consultation between You and Your attending Physician.</p> <p>Reconstructive breast surgery following a mastectomy will be covered regardless of the lapse of time since the mastectomy.</p> <p><u>Post-Mastectomy Care:</u>            Following a Medically Necessary mastectomy, the decision whether to discharge the Member is made by the attending Physician in consultation with the Member. The length of a post-mastectomy inpatient stay is based on the unique characteristics of each Member, including health and medical history.</p>	Prior Authorization is required.
<b>Cardiac Rehabilitation Therapy (Outpatient)</b>	Covered Service.	No Prior Authorization required.
<b>Chemotherapy for Cancer</b>	Covered Service.	Prior Authorization may be required for certain services and diagnostic treatments.

<b>SCHEDULE OF COVERED SERVICES</b>		
<b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS, AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Child Wellness Care</b>	<p>Coverage is provided for medical history, complete physical exam, development assessment, appropriate immunizations, and lab testing in accordance with prevailing medical standards for Covered Dependents through age seventeen (17).</p> <p>Preventative eye and ear examinations by any Participating Physician or other qualified health professional to determine need for correction, for children through age seventeen (17).</p>	Prior Authorization may be required for certain services and diagnostic treatments.
<b>Clinical Trials</b>	Clinical trials based on Medical Necessity and in accordance with regulatory guidelines, including clinical drug trials to treat children's cancer.	Prior Authorization is required.
<b>Colorectal Cancer Screenings</b>	Covered Service.	Prior Authorization may be required for certain services and diagnostic treatments.
<b>Dental-Related Anesthesia and Hospital or Ambulatory Facility Charges</b>	<p>Dental-related anesthesia and Hospital or facility charges for dental services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for:</p> <ul style="list-style-type: none"> <li>• children seven (7) years of age or younger;</li> <li>• persons with serious mental or physical conditions; and</li> <li>• persons with significant behavioral problems;</li> </ul> <p>where the Provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedure(s).</p>	Prior Authorization of the facility is required.

<b>SCHEDULE OF COVERED SERVICES</b> <b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS, AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Dental &amp; Oral Surgery Services</b>	<p>Covered Service for:</p> <p>Removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate.</p> <p>Coverage is limited to the functional restoration of structures and treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums when You seek treatment within twenty-four (24) hours of the accidental injury.</p>	Prior Authorization is required.
<b>Dental &amp; Oral Surgery Services for Treatment of TMJ</b>	Surgical and non-surgical medical treatment of temporomandibular joint dysfunction (TMJ) is covered if a Participating Physician or dentist administers the treatment. Treatment for TMJ may include surgery for the correction of the bone or joint structure of the maxilla or mandible, such that the normal character and essential function of such bone structure is restored. Non-surgical treatment may include history and examination; diagnostic radiographs; splint therapy; and diagnostic or therapeutic masticatory muscle and temporomandibular joint injections.	Prior Authorization is required.
<b>Diabetic Treatment, Supplies and Equipment</b>	<p>Coverage is provided for Medically Necessary equipment, supplies, pharmacologic agents and outpatient self-management training and education, including medical nutrition therapy.</p> <p>Medically necessary equipment, supplies and pharmacological agents include: Glucometers; test strips and related accessories for glucose monitors; insulin; injection aids and supplies; injection devices; insulin cartridges; insulin pumps; insulin infusion devices; oral agents for diabetes maintenance; and other equipment, supplies and drugs determined to Medically Necessary and consistent with the standards of the American Diabetes Association.</p> <p>Routine foot care such as removal or reduction of corns and calluses, and clipping of the nails.</p>	<p>Prior Authorization may be required for certain services and diagnostic treatments.</p> <p>The following are covered under Your Prescription Drug Rider (if included):</p> <ul style="list-style-type: none"> <li>• Oral medications;</li> <li>• Test strips;</li> <li>• Lancets;</li> <li>• Syringes; and</li> <li>• Insulin.</li> </ul>

<b>SCHEDULE OF COVERED SERVICES</b>		
<b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS, AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Dialysis</b>	Covered Service for: Hemodialysis and peritoneal dialysis provided by Participating outpatient or inpatient facilities or vendors.  Home hemodialysis, equipment, supplies, and maintenance are covered for homebound Members as certified by their attending Physician.	Prior Authorization is required
<b>Disposable Supplies</b>	Covered Service only for ostomy and disposable diabetic supplies.	No Prior Authorization required.
<b>Durable Medical Equipment (DME)</b>	Covered Service when determined to provide therapeutic benefits or to enable the Member to perform certain tasks that they are unable to perform otherwise due to certain medical conditions and/or illness, and when <u>all</u> of the following circumstances apply: (1) it can withstand repeated use; (2) it is primarily and customarily used to serve a medical purpose; (3) it is generally not useful to a person in the absence of illness or injury; (4) it is appropriate for use in the home; and (5) it is not otherwise excluded under Section 6.	Prior Authorization may be required.
<b>Emergency Services</b>	Covered Service for those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his/her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in: a. placing the Member's health in serious jeopardy; b. placing the health of a pregnant Member and the health of her unborn child in serious jeopardy; c. serious impairment to bodily function; or d. serious dysfunction of any bodily organ or part.  Emergency Services are covered whether provided by Participating or Non-Participating Providers.	No Prior Authorization required.  Payment of services shall be based on retrospective review of Your presenting history, symptoms and hospital records.  If Emergency Services are provided by a Non-Participating Provider, follow-up services must be performed by a Participating Provider.  Emergency Services for psychiatric and substance abuse emergency care is covered under Your Mental Disorders and Substance-Related Disorders Rider.

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<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Eyeglasses and Corrective Lenses</b>	Covered Service for the first pair of eyeglasses or corrective lenses following cataract surgery.	No Prior Authorization required.
<b>Family Planning</b>	Covered Services include sterilization for both sexes, counseling, treatment and follow-up, information on birth control, insertion and removal of intra-uterine devices, implantable contraceptives and measurement for contraceptive diaphragms.	No Prior Authorization required.  Prescription contraceptives are only Covered under Your Prescription Drug Rider (if included).
<b>Genetic Counseling and Testing</b>	Covered Service for: <ul style="list-style-type: none"> <li>• Genetic counseling and studies that are needed for diagnosis and treatment of genetic defects when the result of the genetic test will directly impact treatment for the Member; or</li> <li>• There is a history of an inheritable genetic disease and the published Peer-Reviewed Medical Literature documents that its use will improve outcomes; or</li> <li>• There is a substantial familial risk for being a carrier for a particular detectable mutation that is recognized to be attributable to a specific genetic disorder.</li> </ul>	Prior Authorization is required.
<b>Health Education</b>	Diabetic education and nutritional counseling are Covered Services when provided: <ol style="list-style-type: none"> <li>(1) by a Registered Dietician or Participating Physician; and</li> <li>(2) in connection with morbid obesity, diabetes, coronary artery disease, pregnancy, renal disease or hyperlipidemia.</li> </ol>	No Prior Authorization required.

<p align="center"><b>SCHEDULE OF COVERED SERVICES</b>  <b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE</b>  <b>MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS,</b>  <b>AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b></p>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Home Health Care</b>	<p>Covered when <b>all</b> of the following requirements are met:</p> <ol style="list-style-type: none"> <li>(1) the service is ordered by a Participating Physician;</li> <li>(2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist;</li> <li>(3) the services are an alternative to hospitalization;</li> <li>(4) part-time intermittent services are required;</li> <li>(5) a treatment plan has been established and periodically reviewed by the ordering Physician;</li> <li>(6) the services are Authorized by the Health Plan;</li> <li>(7) the agency rendering services is Medicare-certified and licensed by the State of location; and</li> <li>(8) the Member is homebound as certified by his/her attending Physician.</li> </ol>	Prior Authorization is required.
<b>Hospice</b>	<p>Covered if <b>all</b> of the following conditions are met:</p> <ul style="list-style-type: none"> <li>• You elect to receive care by a hospice;</li> <li>• Your Provider certifies that You have a life expectancy of six (6) months or less;</li> <li>• Before the services are provided, Your Provider prepares a written treatment plan authorizing the services; and</li> <li>• A state licensed hospice within the Service Area is providing Medically Necessary hospice services.</li> </ul>	Prior Authorization is required.
<b>Immunizations/ Vaccines</b>	<p>Covered if in accordance with the Georgia Department of Human Resources guidelines.</p> <p>Immunization Coverage is consistent with FDA indications, American Academy of Pediatrics and the Center for Disease Control, if not excluded under Section 6.</p>	No Prior Authorization required.

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<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Infertility Services</b>	Covered Service.	No Prior Authorization required.
<b>Inpatient Hospital Care</b>	Coverage is dependent on the establishment of Medical Necessity for the care.  Semi-private accommodations . Private, if determined to be Medically Necessary.	Prior Authorization is required unless emergency admission.
<b>Inpatient Rehabilitation Facility</b>	Covered Service if able to participate in at least three (3) hours of therapy each day and significant improvement is demonstrated.	Prior Authorization is required.
<b>Laboratory Services</b>	Covered Service.	No Prior Authorization required if Participating laboratory is used.
<b>Mammograms</b>	Covered Service.	No Prior Authorization required.
<b>Maternity Services</b>	Covered: <ul style="list-style-type: none"> <li>• Hospital and professional services before and during confinement, and during the postpartum period, including complications of pregnancy (mother) and care of the newborn child from the moment of birth; and necessary care and treatment of illness, injury, and congenital defects of the infant.</li> <li>• Minimum of forty-eight (48) hours of inpatient care for a mother and her newborn child following a normal vaginal delivery.</li> <li>• Minimum of ninety-six (96) hours of inpatient care for a mother and her newborn child following a cesarean section.</li> <li>• If, following a consultation between the mother and attending Physician, the mother and newborn are discharged prior to postpartum lengths of stay noted above, Coverage shall be provided for up to two (2) follow-up visits, provided that the first visit shall occur within forty-eight (48) hours of discharge with a Participating Provider.</li> </ul>	Authorization is required if You stay beyond forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a cesarean section delivery.  Notification requested for maternity care for case management purposes.

<b>SCHEDULE OF COVERED SERVICES</b> <b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE</b> <b>MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS,</b> <b>AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Orthotics</b>	<p>Covered unless specifically excluded.</p> <p>Orthotics are accessories that provide stability, external control, correction, and support for a body part.</p>	No Prior Authorization required.
<b>Outpatient Services</b>	<p>Covered Services that are not performed in a Physician's office or inpatient setting, and not specified elsewhere in this Schedule of Covered Services.</p> <p>Diagnostic or therapeutic services that are:</p> <ul style="list-style-type: none"> <li>• Routinely performed outside the Physician's office; <b>and</b></li> <li>• Covered Services.</li> </ul>	Prior Authorization may be required for certain services and diagnostic treatments.
<b>Outpatient / Ambulatory Surgery</b>	Covered surgery not performed in a Physician's office or inpatient setting.	Prior Authorization may be required for certain services and diagnostic procedures.
<b>Ovarian Cancer Screenings</b>	Covered Service.	No Prior Authorization required.
<b>Pap Smear</b>	Covered Service.	No Prior Authorization required.
<b>Physician Services</b>	<p>Covered Services:</p> <ul style="list-style-type: none"> <li>• Diagnosis and treatment of illness or injury.</li> <li>• Preventive health services including periodic physical examinations for adults; child wellness care and routine immunizations; and diagnostic screening procedures for cancer surveillance.</li> <li>• Medically Necessary services rendered in an inpatient or outpatient facility.</li> <li>• Second opinions rendered by a Participating Physician.</li> <li>• Immunizations that are normally rendered in a Physician's office.</li> <li>• Medically Necessary X-rays, EKGs and other diagnostic procedures when obtained at a Participating Provider's office.</li> <li>• Laboratory services, when performed and billed in a Participating Physician's office.</li> </ul>	Prior Authorization may be required for certain services and diagnostic treatments.

<b>SCHEDULE OF COVERED SERVICES</b> <b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE</b> <b>MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS,</b> <b>AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Prostate Cancer Screenings</b>	Covered Service.	No Prior Authorization required.
<b>Prosthetics</b>	Prosthetic devices which replace an external body part and are utilized for a specific patient and not otherwise excluded are Covered when Medically Necessary.	Prior Authorization is required, including refittings or replacements due to structural change in anatomy.
<b>Pulmonary Rehabilitation Therapy (Outpatient)</b>	Covered Service.	No Prior Authorization required.
<b>Radiation Therapy</b>	Covered Service.	Prior Authorization may be required for some therapies.
<b>Radiology</b>	Diagnostic radiology is covered, unless determined to be Experimental or Investigational.	Prior Authorization may be required for some procedures.
<b>Reconstructive Surgery</b>	<p>The following reconstructive surgeries are covered:</p> <ul style="list-style-type: none"> <li>• Surgery and associated services to repair disfigurement resulting from an injury;</li> <li>• Services associated with reconstructive surgery necessary to correct disfigurement incidental to a previous surgery.</li> <li>• Services associated with a surgery that substantially improves functioning of any malformed body part, unless specifically excluded elsewhere in this Agreement.</li> </ul>	Prior Authorization is required.

<b>SCHEDULE OF COVERED SERVICES</b> <b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS, AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Short-Term Therapies:</b> ~ <b>Occupational Therapy</b> ~ <b>Physical Therapy</b> ~ <b>Speech Therapy</b>	Covered:  Medically Necessary restorative services designed to restore normal function or impairment only due to trauma, stroke, a surgical procedure, or other acute condition, and significant improvement will be achieved through relatively short-term therapy.	No Prior Authorization required.
<b>Skilled Nursing Facility</b>	Covered Service when deemed Medically Necessary by the Health Plan in lieu of hospitalization.	Prior Authorization for skilled nursing beds is required.
<b>Telemedicine Services</b>	<p>“Telemedicine” means the practice, by a duly licensed Physician or other health care Provider acting within the scope of such Provider’s practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient.</p> <p><b>Standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof, do not constitute telemedicine services.</b></p> <p>Telemedicine services are covered if the services are appropriately provided in accordance with:</p> <ul style="list-style-type: none"> <li>• applicable Georgia laws; and</li> <li>• generally accepted health care practices and standards which prevail in the professional community in which the care is rendered and at the time the services were provided.</li> </ul>	Prior Authorization may be required.

<b>SCHEDULE OF COVERED SERVICES</b> <b>COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY CHC TO BE</b> <b>MEDICALLY NECESSARY, PROVIDED BY PARTICIPATING PROVIDERS,</b> <b>AND NOT SPECIFICALLY EXCLUDED UNDER SECTION 6</b>		
<b>SERVICE OR SUPPLY</b>	<b>CRITERIA AND COVERAGE PROVIDED</b>	<b>AUTHORIZATION REQUIREMENTS AND LIMITATIONS</b>
<b>Transplants</b>	<p>Covered:</p> <ul style="list-style-type: none"> <li>• Services related to Medically Necessary organ transplants if the covered transplant services are performed at a Coventry Transplant Network Facility.</li> <li>• Donor screening tests when CHC is the primary insurer and the testing is performed at a facility approved by the Health Plan. Donor screening tests are subject to a lifetime benefit maximum of ten thousand dollars (\$10,000).</li> <li>• If the donor is not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a covered Member will be covered for the duration of the contract of the covered Member.</li> <li>• Travel expenses for Members and living donors are covered according to Our transplant travel benefit, as long as CHC is the primary insurer and a Coventry Transplant Network Facility is used.</li> <li>• In order to be covered, transplants must be rendered by a Coventry Transplant Network Facility. <b>Transplants that are provided at a non-Coventry Transplant Network Facility, <u>even if the non-Coventry Transplant Network Facility is a Participating Provider</u>, are <i>not</i> covered.</b></li> </ul>	<p>Prior Authorization is required for all covered transplant and donor services.</p>
<b>Urgent Care</b>	<p>Covered urgent care for an unexpected illness or injury that does not qualify as an emergency but requires prompt medical attention.</p>	<p>No Prior Authorization required.</p>

## **SECTION 6**

### **EXCLUSIONS AND LIMITATIONS**

The Health Plan does not cover the following items, except as specifically addressed elsewhere in this Certificate of Coverage:

#### **ALTERNATIVE TREATMENTS**

1. Acupuncture.
2. Behavior modification.
3. Biofeedback.
4. Colonic therapy.
5. Hypnotherapy.
6. Massage therapy.
7. Naturopathy.
8. Sleep therapy.
9. Vax-D therapy.
10. Any other alternative treatments as defined by the Health Plan and not specified above.

#### **COMFORT OR CONVENIENCE**

1. Custodial and domiciliary care, residential care, protective and supportive care including, but not limited to, educational services, and convalescent care.
2. Home services to help meet personal, family, and/or domestic needs, including, but not limited to, home health aids, activities of daily living such as bathing, dressing, eating and preparing meals, shopping, performing general household services, and taking medication.
3. Personal comfort and convenience items, including but not limited to, televisions and telephones.
4. Private duty nursing.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners.
  - Air and water purifiers and filters.
  - Batteries and battery chargers.
  - Dehumidifiers.
  - Environmental controls.
  - Humidifiers.
  - Protective bed coverings for dust mite allergies or enuresis.
6. Devices, implants and computers to assist in communication and speech.
7. Durable medical equipment for comfort or convenience such as:
  - Bed boards; over-bed tables; flotation devices.
  - Bath and toilet lifts; chair lifts.
  - Chairs and rails; wheelchair trays.
  - Physical fitness equipment; exercise equipment; ultraviolet and/or tanning equipment.
  - Stethoscopes; blood pressure gauges; breast pumps.
  - Elastic support stockings (gradient less than 20 mm of mercury)..
  - Light box therapy.
  - Lymphedema sleeves (unless covered under Section 5).

#### **DENTAL / ORAL**

1. Care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial).
2. Dental care, appliances, implants, or x-rays, including any Physician services or X-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums.
3. Dentures.

4. Fixed or removable appliances which involve movement or repositioning of the teeth, including orthodontia.
5. Oral Surgery required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, involving removal of symptomatic bony impacted third molars, wisdom teeth and associated services except as specified in Section 5.
6. Orthodontia and related services.
7. Root canal.
8. Surgery for impacted teeth.
9. Surgery involving structures directly supporting the teeth.
10. Treatment of missing, malpositioned or supernumerary teeth, even if part of congenital anomaly.

#### **DRUGS**

1. Growth hormones.
2. Immunizations and vaccines for travel, immigration or employment.
3. Over-the-counter drugs and treatments.
4. Prescription drugs, unless covered under a Rider.
5. Self-injectable medications[, unless covered under a Rider].

#### **EXAMS AND TESTING**

1. Educational testing or psychological testing, unless part of a treatment program for Covered Services.
2. Exams for employment, school, camp, sports, insurance, adoption, immigration, marriage or those ordered by a third party.
3. Exams to obtain or maintain a license of any type.
4. Executive physicals.
5. Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when employer requested, or when required for school.

#### **EXPERIMENTAL OR INVESTIGATIONAL**

1. Procedures, treatments, injectables or devices determined by the Health Plan to be Experimental or Investigational.

#### **FOOT CARE**

1. Foot orthotics, except for the treatment of patients with diabetes.
2. Orthopedic shoes and other supportive devices for the feet.
3. Routine foot care, such as removal or reduction of corns and calluses, nail trimming, cutting or debriding, except for patients with diabetes or ischemic vascular disease.
4. Treatment of flat feet, fallen arches and chronic foot strain.
5. Treatment of subluxation of the foot.

#### **MEDICAL SUPPLIES AND APPLIANCES**

1. Any item or device commonly available without a prescription.
2. Braces, supports and prosthetics needed for athletic participation or employment.
3. Deluxe equipment, such as motorized beds or chairs, when standard equipment is adequate.
4. Disposable outpatient supplies, such as sheaths, bags, elastic garments, bandages, incontinence pads, syringes, needles, home testing kits, blood or urine testing supplies (unless otherwise specified as covered, such as for diabetes treatment).
5. Over-the-counter products, including splints, braces and supplies such as ACE wraps, elastic supports, and finger splints, and relief bands for motion sickness.
6. Pools, spas and whirlpools.
7. Residential structural modifications to facilitate the use of equipment including ramps.
8. Repair or replacement due to Your inappropriate use or maintenance of durable medical equipment and external prosthetic items and devices; replacement required because the equipment or device is lost, misplaced or stolen.

9. Replacement, repair or maintenance of any durable medical equipment or prosthetic item or device that is not covered.
10. Smoking cessation aids.
11. Ultraviolet and/or tanning equipment.

#### **NUTRITION**

1. Food, food supplements, additives, formula and enteral feedings, and donor breast milk.
2. Nutritional and electrolyte supplements.
3. Vitamins and supplements.
4. Special food items.

#### **PHYSICAL APPEARANCE**

1. Blepharoplasty.
2. Breast augmentation and reductions, unless required to be covered by the federal Women's Health and Cancer Rights Act of 1998.
3. Cosmetic Services and Surgery and the complications incurred as a result of those services and surgeries, except for services to correct a congenital defect during the first year of life. Cosmetic surgery means surgery to change the texture or appearance of the skin or the relative size or position of any part of the body when such surgery is performed primarily for psychological purposes and is not needed to correct or substantially improve a bodily function. Removal of skin lesions is considered cosmetic unless the lesions interfere with normal body functions or malignancy is suspected.
4. Complications of non-covered procedures.
5. Gastric bypass surgeries (both laparoscopic or open) including but not limited to Roux-en-Y procedures, jejunioileal bypass, gastric banding, biliopancreatic bypass, gastroplasty, and gastric balloon.
6. Hair analysis, wigs and hair transplants.
7. Liposuction.
8. Panniculectomy and abdominoplasty.
9. Scar or tattoo removal or revision procedures, such as but not limited to salabrasion or chemosurgery.
10. Sex transformation procedures, treatments, or studies.
11. Surgery performed solely to address psychological or emotional factors.
12. Treatment of gynecomastia (abnormal breast enlargement in males).
13. Treatment of excessive sweating (hyperhidrosis).
14. Weight reduction therapy, supplies and services, including but not limited to diet programs, tests, examinations or services and medical or surgical treatments such as balloon dilation, wiring of the jaw, and other procedures of a similar nature whether or not they are under medical supervision.

#### **PROVIDER SERVICES**

1. Any portion of a Provider's charge which is due from the Member but which has been waived.
2. Any services rendered by persons not specified by the Health Plan as licensed Providers of health care.
3. Any services or supplies provided which are not within the scope of licensure or certification of the Provider.
4. Care rendered to You by a relative or Yourself.
5. Charges resulting from Your failure to appropriately cancel a scheduled appointment.
6. Medical evacuation.
7. Mental health services, unless covered under a Rider.
8. Newborn home delivery including midwife services.
9. Non-Emergency Services provided at an emergency facility.
10. Phone and email consultations.
11. Private inpatient room, unless Medically Necessary.
12. Professional fees for oral surgeons and dental providers associated with dental-related anesthesia and Hospital or ambulatory facility charges which the Health Plan is required to cover.

13. Retail Pharmacist consultations.
14. Services provided by a Chiropractor, unless covered under a Rider.

### **REPRODUCTION**

1. Services rendered to infants born to, or adopted by, enrolled Dependent children.
2. Reversal of voluntary sterilization.
3. Sexual dysfunction aids, implants, prostheses, and treatment.
4. Surrogate parenting, including but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother, or sperm donation.

### **SERVICES PROVIDED UNDER ANOTHER PLAN**

1. Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan.
2. Any war-related sickness, injury, services or care for military services-connected disabilities and conditions regardless of whether You are or are not legally entitled to Veteran's Administration services and for which facilities are reasonably accessible to You.
3. Services and supplies for students which schools are required to provide by law.
4. Vocational therapy.
5. Work hardening programs.
6. Work related injuries or illnesses eligible for coverage by Workers' Compensation.

### **THERAPY AND TREATMENTS**

1. Cardiac rehabilitation Phase III therapy (unmonitored rehabilitation).
2. Chelation therapy.
3. Marriage or relationship counseling; family counseling; vocational or employment counseling; and sex therapy.
4. Long-term or maintenance therapy.

### **TRANSPLANTS**

1. Transplant services not authorized by Us.
2. Donor screening tests.
3. Any Experimental or Investigational procedures.
4. Travel and lodging expenses incurred by a Member who resides less than one hundred fifty (150) miles from the Coventry Transplant Network Facility.
5. Travel and lodging expenses incurred by a Member for transplant services obtain at a non-Coventry Transplant Network Facility.
6. The cost of any care, including complications, arising from an organ donation by a Member when the recipient is not a Covered individual.

### **TRAVEL**

1. All travel outside the United States, including travel to return to the United States.
2. Health services provided in a foreign country, unless required as Emergency Services.
3. Non-emergent ambulance service, except as specified in Section 5.

### **VISION AND HEARING**

1. Corneal topography, unless done as part of a transplant.
2. Eye exercises and therapy (orthoptics).
3. Eye glasses, contact and corrective lenses unless covered under a Rider.
4. Eye examinations, unless covered under a Rider.
5. Fitting charge for hearing aids, eyeglasses or contact lenses.
6. Hearing aids as well as other assistive or hearing devices and implants.
7. Surgery that is intended to allow you to see better without eyeglasses or contacts, or over vision correction, including radial keratotomy, laser and other refractive eye surgery.

## **ALL OTHER EXCLUSIONS**

1. Any care incurred while the individual is not eligible for Coverage.
2. Any service or supply that is not Medically Necessary.
3. Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-covered service.
4. Any service or supply for which You have no financial liability or legal responsibility to pay, or that was provided at no charge.
5. Services and supplies furnished under or as part of a study, grant or research program.
6. Care received while You are incarcerated.
7. Court-ordered services or services that are a condition of probation or parole.
8. Non-emergent out-of-network services.
9. Care received outside of the United States, except for Emergency Services.
10. Treatment, services and supplies required to treat an injury or sickness a contributing cause of which was the Member's commission of an act that could be classified as a felony, misdemeanor, or other illegal activity, regardless of whether criminal charges are ultimately filed against the Member or a conviction occurs.
11. Any service or supply that is not in accordance with Our Utilization Management policies and procedures (except for Emergency Services).
12. [Any charges for Hospital errors that are not reimbursed by Medicare.]

## **SECTION 7**

### **COORDINATION WITH OTHER COVERAGE**

**7.1 Coordination With Other Plans.** This coordination of benefits ("COB") provision applies when a Member has health care Coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the Plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense.

#### **7.2 Definitions.**

**7.2.1** A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

**7.2.1.1** "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law and subject to the rules on COB with Medicare set forth below.

**7.2.1.2** "Plan" does not include: individual or family insurance; close panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of \$200 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental Plans, unless permitted by law.

- 7.2.1.3** Each contract for coverage under Section 7.2.1.1 or 7.2.1.2 is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- 7.2.2** The order of benefit determination rules determine whether We are a “Primary” Plan or “Secondary” Plan when compared to another Plan covering You or Your covered Dependent. When We are Primary, Our benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When We are Secondary, Our benefits are determined after those of another Plan and may be reduced because of the Primary Plan’s benefits.
- 7.2.3** “Allowable Expense” means a health care service or expense including Deductibles and Copayments, that is covered, at least in part by any of the Plans covering You or Your covered Dependent. When a Plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are **not** Allowable Expenses:
- 7.2.3.1** If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient’s stay in a private hospital room is otherwise a covered benefit) is not an Allowable Expense.
- 7.2.3.2** If a Member is covered by two (2) or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the Plan’s negotiated fees is not an Allowable Expense.
- 7.2.3.3** If a Member is covered by one (1) Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan’s payment arrangements shall be the Allowable Expense for all Plans.
- 7.2.3.4** The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, Precertification of admissions, and preferred Provider arrangements.
- 7.2.4** “Claim Determination Period” means a calendar year. However, it does not include any part of a year during which a Member has no coverage under this Health Plan, or before the date this COB provision or a similar provision takes effect.
- 7.2.5** “Closed Panel Plan” is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- 7.2.6** “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.

### **7.3 Order of Benefit Determination Rules.**

When two (2) or more Plans pay benefits, the rules for determining the order of payment are as follows:

- 7.3.1** The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
- 7.3.2** A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always Primary. There is one exception: 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 Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- 7.3.3** A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.
- 7.3.4** The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.
- 7.3.4.1 Non-Dependent or Dependent.** The Plan that covers the Member other than as a Dependent, for example as an employee, Member, Subscriber or retiree is Primary and the Plan that covers the Member as a dependent is Secondary. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Member as a dependent; and Primary to the Plan covering the Member as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, Member, Subscriber or retiree is Secondary and the other Plan is Primary.
- 7.3.4.2 Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one Plan is:
- a. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
    - (i) The parents are married;
    - (ii) The parents are not separated (whether or not they ever have been married); or
    - (iii) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is Primary.
  - b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.
  - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
    - (i) The Plan of the Custodial Parent;
    - (ii) The Plan of the spouse of the Custodial Parent;
    - (iii) The Plan of the noncustodial parent; and then
    - (iv) The Plan of the spouse of the noncustodial parent.

**7.3.4.3 Active or inactive employee.** The Plan that covers a member as an employee who is neither laid off nor retired, is Primary. The same would hold true if a member is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

**7.3.4.4 Continuation Coverage.** If a Member whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the Member as an employee, Member, Subscriber or retiree (or as that Member's dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

**7.3.4.5 Longer or shorter length of Coverage.** The Plan that covered the Member as an employee, Member, Subscriber or retiree longer is Primary.

**7.3.4.6** If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, We will not pay more than We would have paid had We been the Primary Plan.

#### **7.4 Coordination of Benefits with Medicare.**

Under the terms of this Health Plan, Medicare will pay primary, secondary or last to the extent stated in federal law. In the event that You are eligible for Medicare Parts A, B, and/or D, We will base Our payment upon the benefits covered by the applicable Medicare Part, regardless of whether or not You are actually enrolled.

The following Coordination of Benefits information is based on federal law as of the date that this Agreement was written. We reserve the right to make changes to these rules in the event that we are required to do so under federal law.

If you have questions about how this Health Plan coordinates with Your Medicare coverage, please contact our Customer Services Department at (800) 395-2545, or you may call the Centers for Medicare and Medicaid Services at 1-800-MEDICARE (800-633-4227).

##### **7.4.1 Active Employees and Spouses Age 65 and Older.**

- a. If an employee is eligible for Medicare and works for a Group with fewer than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Health Plan Year, then Medicare will be the primary payer. Medicare will pay its benefits first. We will pay benefits on a secondary basis.
- b. If an employee works for a Group with more than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Health Plan Year, We will be primary. However, an Employee may decline Coverage under this Health Plan and elect Medicare as primary. In this instance, We, by law, cannot pay benefits secondary to Medicare for Medicare covered services.
- c. You will continue to be covered by this Health Plan as primary unless You (a) notify Us, in writing, that You do not want benefits under this Health Plan or (b) otherwise cease to be eligible for benefits under this Health Plan.

#### **7.4.2 Retired Employees Age 65 and Older.**

If You are eligible for Medicare and are covered under this Health Plan as a retiree by Your or Your Spouse's former employer, then Medicare is the primary payer. We will pay benefits on a secondary basis.

#### **7.4.3 Disability.**

- a. If You are under age sixty-five (65) and eligible for Medicare due to disability, and actively work for a Group with fewer than one-hundred (100) employees, then Medicare is the primary payer. We will pay benefits on a secondary basis.
- b. If You are age sixty-five (65) or older and actively work for a Group with at least one-hundred (100) employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below), We will be primary for You and Your eligible Dependents and Medicare will pay benefits on a secondary basis.

#### **7.4.4 End Stage Renal Disease.**

If You are eligible for Medicare due to End Stage Renal Disease (ESRD), We will be primary for the first thirty (30) months or as otherwise required by federal law. If We are currently paying benefits as secondary to another health plan, that other health plan will continue paying primary upon Your entitlement to Medicare due to ESRD.

### **7.5 Right to Receive and Release Needed Information.**

#### **7.5.1 By accepting Coverage under this Agreement You agree to:**

- a. Provide Us with Information about other coverage and promptly notify Us of any coverage changes;
- b. Give Us the right to obtain information as needed from others to coordinate benefits; and
- c. Return any excess amounts to Us if We make a payment and later find that the other coverage should have been primary.

**7.6 Right of Recovery.** If You or Your covered Dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this plan, We may have a right of recovery. Our right of recovery shall be limited to the recovery of the reasonable cash value of any services provided or benefits paid for identical covered medical services or expenses under this plan, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery may include compromise settlements. You or Your attorney must inform Us of any legal action or settlement agreement at least ten (10) days prior to settlement or trial. We will then notify You of the amount We seek to recover for benefits paid. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

## **SECTION 8**

### **COMPLAINTS AND APPEALS**

We maintain both informal and formal procedures to resolve Member Inquiries, Complaints, and Appeals. These processes give Members the opportunity to ask Us to review any matter related to Covered Services, including but not limited to:

- Issues about the scope of Coverage for health care services;
- Denial of care, services, and/or claims;
- Member rights; and
- The quality of the health care service received.

#### **8.1 Definitions of Terms Used.**

For the purpose of Section 8, the following terms and definitions apply:

- Appeal. An Appeal is a request by the Member or Member's Authorized Representative for consideration of an Adverse Benefit Determination of a health service request benefit, or benefit payment that the Member believes he or she is entitled to receive.
- Adverse Benefit Determination. A denial of a request for Coverage of a service or a failure to provide or make payment (in whole or in part) for a service. An Adverse Benefit Determination also includes, but is not limited to, any reduction or termination of Coverage for a Covered Service. An Adverse Benefit Determination based in whole or in part on a medical judgment includes the failure to cover services because they are determined to be Experimental or Investigational, cosmetic, out-of-area referrals, not Medically Necessary or inappropriate.
- Authorized Representative. An Authorized Representative is an individual authorized by the Member to act on the Member's behalf in obtaining claims payment or during the Appeals process. A Provider may act on behalf of a Member with the Member's express consent, or without the Member's express consent for Emergency Services.
- Complaint. Any expression of dissatisfaction expressed by a Member or Member's Authorized Representative regarding Coverage that does not rise to level of an Appeal.
- Inquiry. Any question from a Member or Member's Authorized Representative regarding Coverage that does not rise to the level of an Appeal (e.g., benefits information, claim status, or eligibility).
- Post-service Appeal. Post-service Appeals are those Appeals for which a requested service has received an Adverse Benefit Determination. This excludes instances where Prior Authorization is required for the service.
- Pre-service Appeal. Pre-service Appeals are those Appeals for which a requested service requires Prior Authorization and an Adverse Benefit Determination has been rendered.
- Urgent Care or Expedited Appeal. An Urgent Care Appeal is an Appeal of an Adverse Benefit Determination that must be reviewed under an Expedited Appeal process because the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of the Member; or (b) the Member's ability to regain maximum function. In determining whether an Appeal involves urgent care, We will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

An Urgent Care Appeal is also an Appeal of an Adverse Benefit Determination involving: (a) care that the treating Physician deems urgent in nature; or (b) the treating Physician determines that a delay in the care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

## **8.2 Procedure for Filing an Inquiry or Complaint.**

If a Member has a question regarding any aspect concerning Covered Services, he/she may contact a Customer Service Representative to file an Inquiry by telephone or in writing, expressing the details of the question.

If a Member is dissatisfied with any aspect concerning Covered Services, he/she may contact a Customer Service Representative to file a Complaint by telephone or in writing, expressing the details of the Member's dissatisfaction.

If the Member does not receive satisfactory resolution to a Complaint/Inquiry regarding an Adverse Benefit Determination of a health service request or benefit that the Member believes he or she is entitled to receive, the Member may file a written Appeal with Us at the address below. The written request for Appeal must include:

- Patient name and number;
- Member name and number;
- Provider name;
- Dates of service under Appeal;
- Member's and/or Member's Authorized Representative's mailing address;
- Clear indication of the remedy or corrective action being sought and an explanation of why We should "reverse" the Adverse Benefit Determination;
- Copy of documentation to support the reversal of decision; and
- Clear indication of the reason for dissatisfaction.

The written request for an Appeal must be filed within one hundred eighty (180) days of the date of the initial Adverse Benefit Determination (e.g., EOB for denied claims) has been sent to the Member. We will provide a review that takes into account all comments, documents and records submitted by the Member, without regard as to whether the information was submitted at the time of the initial benefit determination. Members may request, free of charge, copies of all relevant documents, records, and other information related to the issue except proprietary or privileged information. The review will not afford deference to the initial denial and will be conducted by an individual who did not make the initial denial, nor the individual's subordinate. In deciding an Appeal that was made in whole or in part on a medical judgment, a duly licensed health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.

Our address and phone number are as follows:

**Coventry Health Care of Georgia, Inc.**  
**1100 Circle 75 Parkway, Suite 1400**  
**Atlanta, Georgia 30339**  
**(800) 395-2545**

Members may also file written Complaints with:

Georgia Department of Insurance  
Seventh Floor, West Tower Floyd Building  
Martin Luther King, Jr. Drive  
Atlanta, GA 30333  
(404) 656-2056

or

Georgia Department of Human Resources  
Office of Regulatory Services  
Peachtree Street, NW, Suite 19-204  
Atlanta, GA 30303  
(404) 657-5550

**8.3 Informal Reconsideration.**

In a situation where an Adverse Benefit Determination is based on Medical Necessity, appropriateness of health care setting, level of care or effectiveness, We shall give the Provider requesting rendering the service an opportunity to request on behalf of the Member an informal reconsideration by the Medical Director or clinical peer making the Adverse Benefit Determination. The request for reconsideration must be received within ten (10) days of the initial adverse determination. The reconsideration shall occur within one (1) working day of the request.

**8.4 Pre-Service Appeal Process.**

**Appeals Involving Medical Judgment (“Clinical Appeals”)**

**First Level Appeal.** A written request of Appeal will be reviewed by a Physician not involved in the initial Adverse Benefit Determination. The Member may submit additional information for review. We shall notify the Member in writing of the Health Plan’s decision within fifteen (15) calendar days from receipt of the request for an Appeal.

**Second Level Appeal.** Members who are dissatisfied with the first level Appeal determination, may Appeal to the Second Level Appeals committee. The Second Level Appeals committee will consist of not less than three (3) persons, at least one (1) member of which shall be a Physician other than the Medical Director and at least one (1) member shall be a health care Provider competent by reason of training and licensure in the treatment or procedure which has been denied. Written request for a Second Level Appeal must be received within thirty (30) days after the First Level Appeal determination has been made. The Member is encouraged to present their case to the committee, and will be notified of the committee’s final decision within fifteen (15) calendar days from receipt of the request.

If the Member is not satisfied with the decision of the Second Level Appeals committee, and if state-specific criteria is met, the Member may request an independent external review from the Georgia Department of Community Health. If criteria is met, the appropriate form to request an external review will be included with the decision letter sent to the Member upholding the denial of Coverage. For more details on the external review process, see Section 8.7, External Review.

**Appeals Involving Administrative Determinations (“Administrative Appeals”)**

Administrative Appeals are subject to only one (1) level of review. A written request of Appeal will be presented for review by the Administrative Appeals committee, which will consist of one (1) to three (3) managers of the Health Plan or designee, who were not involved in the original determination. We shall notify the Member in writing of the committee’s decision within thirty (30) days following the request for an Appeal.

If the Member is not satisfied with the decision of the Administrative Appeals committee, the Member may pursue normal remedies of law.

## **8.5 Post-Service Appeal Process.**

### **Clinical Appeals**

**First Level Appeal.** A written request of Appeal will be reviewed by a Physician not involved in the first case who is a health care Provider competent by reason of training and licensure in the treatment or procedure which has been denied. The Member may submit additional information for review. We shall notify the Member in writing within thirty (30) days from receipt of the request for an Appeal.

**Second Level Appeal.** Members who are dissatisfied with the First Level Appeal determination may Appeal to the Second Level Appeals committee. The Second Level Appeals committee will consist of not less than three (3) persons, at least one (1) member of which shall be a Physician other than the Medical Director and at least one (1) member shall be a health care Provider competent by reason of training and licensure in the treatment or procedure which has been denied. Written request for a Second Level Appeal must be received within thirty (30) days after the First Level Appeal determination has been made. The Member is encouraged to present their case to the committee and will be notified of the committee's final decision within thirty (30) days from receipt of the request.

If the Member is not satisfied with the decision of the Second Level Appeals committee, and if the state specific criteria is met, the Member may request an independent external review from the Georgia Department of Community Health. If criteria is met, the appropriate form to request an external review will be included with the decision letter sent to the Member upholding the denial of Coverage. For more details on the external review process, see Section 8.7, External Review.

### **Administrative Appeals**

Administrative Appeals are subject to only one (1) level of review. A Member's written request of Appeal will be presented for review by the Administrative Appeals committee, which consists of one (1) to three (3) managers of the Health Plan or designee, who were not involved in the original determination. We shall notify the Member in writing of the committee's decision within sixty (60) days from receipt of the request for an Appeal.

If the Member is not satisfied with the decision of the Administrative Appeals committee, the Member may pursue normal remedies of law.

## **8.6 Urgent Care or Expedited Appeals.**

In situations involving Urgent Care Appeals, We shall notify the Member of Our determination as soon as possible, taking into account the emergency, but not later than seventy-two (72) hours after receipt of the request for review of an Adverse Benefit Determination.

## **8.7 External Review.**

**8.7.1 Right to Appeal to an Independent Review Organization.** An eligible Member shall be entitled to Appeal to an independent review organization when the following criteria has been met:

- a. The Member is enrolled under a fully-insured Health Plan; and
- b. The Member has received final written notice of an adverse Medical Necessity outcome pursuant to an Appeal procedure and has exhausted the Health Plan's internal Appeal process or the Health Plan has not complied with the requirements for such a procedure; and

- c. The cost of the Medically Necessary procedure for which the Member would be held responsible is a minimum of five hundred dollars (\$500); or
- d. We determine that a proposed treatment is excluded as experimental under the Agreement, and all of the following criteria are met:
  - (i) The eligible Member has a terminal condition that, according to the treating Physician, has a substantial probability of causing death within two (2) years from the date of the request for independent review or the eligible Member's ability to regain or maintain maximum function, as determined by the treating Physician, would be impaired by withholding the experimental treatment;
  - (ii) After exhaustion of standard treatment as provided by this Certificate of Coverage or a finding that such treatment would be of substantially lesser or of no benefit, the eligible Member's treating Physician certifies that the eligible Member has a condition for which standard treatment would not be medically indicated for the eligible Member or for which there is no standard treatment available under the Certificate of Coverage of the eligible Member more beneficial than the treatment proposed;
  - (iii) The eligible Member's treating Physician has recommended and certified in writing treatment which is likely to be more beneficial to the eligible Member than any available standard treatment;
  - (iv) The eligible Member has requested a treatment as to which the eligible Member's treating Physician, who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the eligible Member's condition, has certified in writing that scientifically valid studies using accepted protocols, such as control group or double-blind testing, published in Peer-Reviewed Medical Literature, demonstrate that the proposed treatment is likely to be more beneficial for the eligible Member than available standard treatment; and
  - (v) A specific treatment recommended would otherwise be included within the eligible Member's Certificate of Coverage, except for the determination by Us that such treatment is experimental for a particular condition.

**8.7.2 Member Representative's Right to Request Independent Review.** The parent or guardian of a minor who is an eligible Member may act on behalf of the minor in requesting an independent review. The legal guardian or representative of an incapacitated eligible Member shall be authorized to act on behalf of the eligible Member in requesting an independent review. An independent review may not be requested by persons other than the eligible Member or a person acting on behalf of the eligible Member.

**8.7.3** The Health Plan will pay the full cost of applying for and obtaining the independent review. The eligible Member and the Health Plan shall cooperate with the independent review organization to provide the information and documentation, including executing releases for medical records, that are necessary for the independent review organization to make a determination of the claim. The decision of the independent review organization is binding.

## **8.8 Independent Review Procedure.**

- 8.8.1** The Department of Community Health (the "Department") shall provide written notification of the name and address of the assigned independent review organization to both the requesting eligible Member and the Health Plan.
- 8.8.2** Within three (3) business days of receipt of the Department's notice of the assigned independent review organization, the Health Plan shall submit to that organization the following:
- a. Any information submitted to the Health Plan by the eligible Member in support of his/her Appeal;
  - b. A copy of the Health Plan contract provisions or Certificate of Coverage; and
  - c. Any other relevant documents or information used by the Health Plan in determining the outcome of the eligible Member's Appeal.
- 8.8.3** Upon request, the Health Plan shall provide a copy of all documents required by this subsection, except for any proprietary or privileged information, to the eligible Member. The Member may provide the independent review organization with any additional information he/she deems relevant.
- 8.8.4** The independent review organization shall request any additional information required for the review from the Health Plan and the eligible Member within five (5) business days of receipt of the required documentation. Any additional information requested by the independent review organization shall be submitted within five (5) business days of receipt of the request, or an explanation of why the additional information is not being submitted shall be provided.
- 8.8.5** Additional information obtained from the eligible Member shall be transmitted to the Health Plan, which may determine that such additional information justifies a reconsideration of the outcome of the Health Plan's Appeals procedure. A decision by the Health Plan to fully cover the treatment in question upon reconsideration using such additional information shall terminate the independent review.
- 8.8.6** The expert reviewer of the independent review organization shall make a determination within fifteen (15) business days after expiration of all time limits set forth in this Section, but such time limits may be extended or shortened by mutual agreement between the eligible Member and the Health Plan. The determination shall be in writing and state the basis of the reviewer's decision. A copy of the decision shall be delivered to the Health Plan, the eligible Member and the Department by at least first-class mail.
- 8.8.7** The independent review organization's decision shall be based upon a review of the information and documentation submitted to it.
- 8.8.8** Information required or authorized to be provided, may be provided by facsimile transmission or other electronic transmission.

## **8.9 Independent Review Determinations.**

- 8.9.1** A decision of the independent review organization in favor of the eligible Member shall be final and binding on the Health Plan and the appropriate relief shall be provided without delay.

- 8.9.2** A determination by the independent review organization in favor of the Health Plan will create a rebuttable presumption in any future actions that the Health Plan's prior determination was appropriate and shall constitute a medical record.
- 8.9.3** In the event that, in the judgment of the treating health care Provider, the health condition of the eligible Member is such that following the standard independent review procedure would jeopardize the life or health of the eligible Member or the his/her ability to regain maximum function, as determined by the treating health care Provider, an expedited review shall be available. The expedited review process shall encompass all elements of the independent review process as enumerated above; provided, however, that a decision by the expert reviewer shall be rendered within seventy-two (72) hours after the expert reviewer's receipt of all available requested documents.

## **SECTION 9**

### **ACCESS TO RECORDS AND CONFIDENTIALITY OF INFORMATION**

To best service You, We need information about You. This information may come from You, Your employer, or other health benefits plan sponsors. Examples include Your name, address, date of birth, marital status, employment information, or medical history. We also receive information from Providers about the health care services You receive. This information may be in the form of health care claims and encounters, medical information, or a service request.

We maintain policies regarding confidentiality, protection and disclosure of Your nonpublic personal information, including policies related to access to medical records. We may collect, use or share nonpublic personal information to perform Our health care operations, arrange for Your treatment, to pay Your claims or for other purposes permitted or required by law. Nonpublic personal information will not be released to third parties including Your employer, researchers or the government without Your or Your authorized representative's consent, except as may be permitted or required by law.

If You have any questions about Our policies or procedures to maintain the confidentiality of nonpublic personal information please contact Our Customer Service Department.

#### **Genetic Testing:**

In the event that We receive information derived from genetic testing that You have undergone, We agree not to use this information for any nontherapeutic purpose. We further agree not to release this information to any third party without Your explicit written consent.

## **SECTION 10**

### **GENERAL PROVISIONS**

#### **10.1 Applicability.**

The provisions of this Agreement shall apply equally to the Subscriber and Dependents and all benefits and privileges made available to You shall be available to Your Dependents.

#### **10.2 Choice of Law.**

This Agreement will be administered under the laws of the State of Georgia.

### **10.3 Discounts and Rebates.**

As a Member of this Plan, You understand and agree that this Plan may receive a retrospective discount or rebate from a Participating Provider or vendor, related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by Members enrolled in any Coventry plan. Though Members shall not share in such retrospective volume-based discounts or rebates, such aggregated rebates will be considered in Our prospective premium calculations.

### **10.4 Discretionary Authority**

We have the discretionary authority to interpret this Plan in order to make eligibility and benefit determinations. We also have the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under this Agreement.

### **10.5 Entire Agreement.**

This Agreement shall constitute the entire agreement between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Agreement that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate Coverage of a Member shall be used in any context to void the Coverage, with respect to which such statement was made or to decrease Benefits hereunder after the Coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

### **10.6 Exhaustion of Administrative Remedies.**

Neither You nor a Group may bring a cause of action hereunder in a court or other governmental tribunal unless and until all administrative remedies set forth in this Agreement have first been exhausted.

### **10.7 Nontransferable.**

No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by Us under this Agreement. Such right to health care service Coverage or other benefits is not transferable.

### **10.8 Policies and Procedures.**

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

### **10.9 Relationship Among Parties Affected by Agreement.**

The relationship between CHC and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of CHC, nor is CHC or any employee of CHC an employee or agent of Participating Providers. Participating Providers shall maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

Neither the Group nor You is an agent or representative of CHC, and neither shall be liable for any acts or omissions of CHC for the performance of services under this Agreement.

### **10.10 Reservations and Alternatives.**

We reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

### **10.11 Severability.**

In the event that any provision of this Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Agreement, which shall continue in full force and effect in accordance with its remaining terms.

### **10.12 Valid Amendment.**

No change in this Agreement shall be valid unless approved by an officer of CHC, and evidenced by endorsement on this Agreement and/or by amendment to this Agreement. Such amendment will be incorporated into this Certificate of Coverage.

### **10.13 Waiver.**

The failure of CHC, the Group, or You to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

## **SECTION 11** **DEFINITIONS**

**Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement.**

### **11.1 “Agreement”**

The Certificate of Coverage and amendments, the Enrollment Application/Health Statements, Schedule of Benefits, Applicable Riders, and the Group Contract together form the Agreement.

### **11.2 “Authorization; Authorize; Prior Authorization; and Pre-Authorization”**

CHC has given approval for payment for a certain service, treatment, procedure, service or supply.. Prior Authorization means approval given before services are rendered. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

### **11.3 “Benefit Year”**

A period of one (1) year commencing on the Group Effective Date (or renewal date) and ending at 12:00 midnight on the last day of the one (1) year period.

#### **11.4 “Coinsurance”**

The percentage of Our allowed amount that You must pay for a Covered Service as noted in Your Schedule of Benefits.

#### **11.5 “Copayment”**

The specific dollar amount that You must pay for a Covered Service as noted in Your Schedule of Benefits.

#### **11.6 “Cosmetic Services and Surgery”**

Plastic or reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

#### **11.7 “Coventry Transplant Network Facility”**

A Provider or Facility designated by Us to provide transplant services and treatment to Members.

#### **11.8 “Covered Services” and “Coverage”**

The services or supplies provided to You for which CHC will make payment, as described in the Agreement.

#### **11.9 “Deductible”**

The dollar amount of medical expenses for Covered Services that You are responsible for paying annually before benefits subject to the Deductible are payable under this Agreement.

#### **11.10 “Dependent”**

Any Member of a Subscriber’s family who meets the eligibility requirements as outlined in this Certificate of Coverage and the Group Contract.

#### **11.11 “Directory of Health Care Providers”**

A paper or electronic listing of Participating Providers. Please be aware the information in the directory is subject to change.

#### **11.12 “Emergency Services”**

Emergency Services means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his/her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in:

1. placing the Member’s health in serious jeopardy;
2. placing the health of a pregnant Member and the health of her unborn child in serious jeopardy;
3. serious impairment to bodily function; or
4. serious dysfunction of any bodily organ or part.

#### **11.13 “Enrollment Application”**

The completed form required for enrollment in the Health Plan, including any Health Statements.

#### **11.14 “Experimental or Investigational”**

A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

1. Any drug not approved for use by the Federal Food and Drug Administration (FDA); any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or any drug that is classified as an Investigational New Drug (IND) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.
2. Any health product or service that is subject to Investigational Review Board (IRB) review or approval.
3. Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered.
4. Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

#### **11.15 “Group”**

The organization or firm contracting with CHC for health care services for Subscribers and their Dependents.

#### **11.16 “Group Contract”**

The contract between the Group and CHC which states that CHC shall arrange for the provision of Covered Services to eligible employees of the Group and their eligible Dependents.

#### **11.17 “Group Effective Date”**

The date of Coverage as determined by the Group and agreed to by Us, as set forth in the Group Contract.

#### **11.18 “Group Enrollment Period”**

The period of time occurring at least once annually during which any eligible employee or dependent may enroll with CHC for Coverage.

#### **11.19 “Health Plan”**

Coventry Health Care of Georgia, Inc.

#### **11.20 “Hospital”**

An institution, operated pursuant to law, which: (a) is primarily engaged in providing Health Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home or similar institution is not a Hospital.

### **11.21 “Medical Director”**

The Physician specified by Us as the Medical Director.

### **11.22 “Medically Necessary” or “Medical Necessity”**

Medically Necessary means those services, supplies, equipment and facilities charges that are not expressly excluded under this Agreement and determined by Us to be:

1. Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
2. Necessary to meet Your health, improve physiological function and required for a reason other than improving appearance;
3. Within generally accepted standards of medical care in the community;
4. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
5. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;
6. Consistent with the diagnosis of the condition at issue;
7. Required for reasons other than comfort for the Member or Member’s family and convenience of Your Physician; and
8. Not Experimental or Investigational as determined by Us under Our experimental procedures determination policy.

### **11.23 “Member”**

Any Subscriber, Dependent or Qualified Beneficiary (as that term is defined under COBRA) who is enrolled for Coverage under this Agreement in accordance with its terms and conditions.

### **11.24 “Member Effective Date”**

The date entered on Our records as the date when Coverage for a Member under this Agreement begins in accordance with the terms of this Agreement, which Coverage shall begin at 12:01 a.m. on such date.

### **11.25 “Non-Participating Provider”**

A Provider who has no direct or indirect written agreement with the Us to provide health services to Members.

### **11.26 “Out-of-Pocket Maximum”**

The limit on the total amount of Coinsurance You must pay out of Your pocket annually for Covered Services.

### **11.27 “Participating Provider”**

A Provider who has entered into a direct or indirect written agreement with Us to provide health services to Members.

### **11.28 “Peer-Reviewed Medical Literature”**

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the uniform Requirements for Manuscripts submitted to biomedical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

### **11.29 “Physician”**

Any Doctor of Medicine, “M.D.”, or Doctor of Osteopathy, “D.O.”, who is currently licensed to practice medicine, surgery or osteopathy.

### **11.30 “Primary Care Physician” and “PCP”**

A Participating Physician who practices in the fields of Internal Medicine, General Practice, Family Practice or Pediatrics who is designated as a PCP by Us and who is responsible for providing care to Members who have chosen and have been accepted as patients by that Physician.

### **11.31 “Provider” and “Provider Network”**

A Physician, Hospital, Skilled Nursing Facility, Home Health Agency, Hospice, pharmacy, podiatrist, optometrist or other health care institution or practitioner, licensed, certified or otherwise authorized by the Health Plan.

### **11.32 “Service Area”**

The geographic area served by CHC, as approved by the Department of Human Resources and Department of Insurance and shown in Section 12, in which CHC’s health services are available and readily accessible to enrollees. CHC’s Service Area is subject to change.

### **11.33 “Subscriber”**

The eligible employee who has elected CHC Coverage for himself and any eligible Dependents through submission of an Enrollment Application and for whom, or on whose behalf, premiums have been received by Us.

### **11.34 “We/Us or Our”**

Coventry Health Care of Georgia, Inc.

### **11.35 “You/Your”**

A Member covered under this Certificate of Coverage.

**SECTION 12**  
**SERVICE AREA DESCRIPTION**

**The current Service Area consists of the following counties:**

Appling County  
Atkinson County  
Baldwin County  
Banks County  
Barrow County  
Bartow County  
Bibb County  
Bleckley County  
Brantley County  
Bryan County  
Bulloch County  
Burke County  
Butts County  
Candler County  
Carroll County  
Chatham County  
Chattooga County  
Cherokee County  
Clarke County  
Clayton County  
Cobb County  
Coffee County  
Columbia County  
Coweta County  
Crawford County  
Dawson County  
DeKalb County  
Dooly County  
Douglas County

Effingham County  
Emanuel County  
Evans County  
Fayette County  
Floyd County  
Forsyth County  
Fulton County  
Gilmer County  
Gordon County  
Greene County  
Gwinnett County  
Habersham County  
Hall County  
Haralson County  
Heard County  
Henry County  
Houston County  
Jackson County  
Jasper County  
Jones County  
Lamar County  
Liberty County  
Lincoln County  
Long County  
Lumpkin County  
Macon County  
Madison County  
McDuffie County  
McIntosh County

Meriwether County  
Monroe County  
Morgan County  
Newton county  
Oconee County  
Oglethorpe County  
Paulding County  
Peach County  
Pickens County  
Pierce County  
Pike County  
Polk County  
Richmond County  
Rockdale County  
Screven County  
Spalding County  
Taylor County  
Troup County  
Twiggs County  
Union County  
Upson County  
Walton County  
Ware County  
Wayne County  
White County  
Wilkes County  
Wilkinson County