BlueChoice

POS

HSA COMPATIBLE

HIGH DEDUCTIBLE HEALTH PLAN

Certificate Booklet

Plan 482

Effective January 1, 2011

This high Deductible health plan policy is designed to be a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts. This Contract may qualify you to make a pre-tax annual contribution to a Health Savings Account (HSA).

NOTICE: Blue Cross and Blue Shield of Georgia does NOT provide tax advice. The Georgia Insurance Department does NOT in any way warrant that this policy meets the federal requirements.

Except for Accidental Injury or Medical Emergency treatment, Out-of-Pocket expenses are up to 30% higher when you receive care from An Out-Of-Network Provider.

F-1681.800 09/2010

NOTICE: YOUR OUT-OF-POCKET EXPENSES ARE HIGHER WHEN YOU RECEIVE CARE FROM OUT-OF-NETWORK PROVIDERS

CERTIFICATE OF COVERAGE

BLUE CHOICE POS
Underwritten by Blue Cross and Blue Shield of Georgia, Inc.
(herein called BCBSGA)

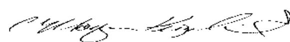
An Independent Licensee of the
Blue Cross and Blue Shield Association
Having issued a
Group Master Contract
To
GEORGIA BANKERS ASSOCIATION INSURANCE TRUST, INC.
hereby certifies that

1. The persons and their eligible family Members (if any) whose names are on file at the office of the Plan Administrator as being eligible for coverage have had the required application for coverage accepted and subscription charge received by BCBSGA. These persons are covered under and subject to all the exceptions, limitations, and provisions of said Group Master Contract for the benefits described herein;
2. Benefits will be paid in accordance with the provisions and limitations of the Group Master Contract; and
3. BCBSGA has delivered to the Plan Administrator the Group Master Contract covering certain persons and their eligible family Members (if any) as Members of this Group program.

The Group Master Contract (which includes this Certificate Booklet, and any riders and amendments) constitutes the entire Contract. All rights which may exist, arise from and are governed by the Group Master Contract and this Certificate Booklet does not constitute a waiver of any of the terms. The Group Master Contract may be inspected at the office of the Plan Administrator.

Coverage under this Certificate will be effective and will continue in effect in accordance with the terms, provisions and conditions of the Group Master Contract. This Certificate of Coverage replaces and supersedes all Contracts and/or Certificates which may have been issued previously by BCBSGA through the Plan Administrator.

The words “we”, “us”, and “our” refer to Blue Cross and Blue Shield of Georgia. The words “you” and “your” refer to the Member, Subscriber and each Covered Dependent.



C. Morgan Kendrick,
President

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Summary of Benefits	In-Network	Out-of-Network
All In-Network care must be received from an In-Network Provider.		
Calendar Year Deductible		
Calendar Year Deductible (In-Network and Out-of-Network combined) Individual – In-Network and Out-of-Network combined (single coverage) Family – In-Network and Out-of-Network combined (covering two or more individuals) ***Subject to change based on a yearly index.**	$3,050 $5,000	
No benefits are payable until the Calendar Year Deductible is satisfied, unless otherwise indicated. For family coverage, all eligible family Members share one combined Deductible.		
All Covered Services are subject to the Deductible and Coinsurance except all preventive care services or unless otherwise stated in this booklet.		
Out-of-Pocket Limit		
Out-of-Pocket Limit Per Calendar year (includes the Deductible) Individual (single coverage) Family (covering two or more individuals) ***Subject to change based on a yearly index.**	 $3,050 $5,000	 $5,950 $11,900
Amounts satisfied toward the Out-of-Network Out-of-Pocket Limit will not be applied toward the In-Network Out-of-Pocket Limit. Amounts satisfied toward the In-Network Out-of-Pocket will not be applied toward the Out-of-Network Out-of-Pocket Limit.		
Percentage Payable (unless otherwise specified) after the applicable calendar year Deductible requirement is met. All payments are based on the Maximum Allowed Amount for Covered Services. The program pays The Member pays The percentage payable after the Out-of-Pocket Limit is met	 100% 0 100%	 70% 30% 100%

Summary of Benefits	In-Network	Out-of-Network
Hospital Services		
Pre-certification is required for all Inpatient admissions and specified Outpatient procedures		
Hospital Inpatient Services Pre-Admission Certification (PAC) is required • Daily room, board and general nursing care at semi-private room rate • ICU/CCU charges • Newborn nursery care • Other Medically Necessary Hospital charges such as diagnostic x-ray and lab services • Physician Services – surgeon, anesthesiologist, radiologist, pathologist	100%	70%
Outpatient Hospital Services/Ambulatory Surgery Center • Facility/Hospital charges include diagnostic x-ray and lab services, surgery and anesthesia • Physician Services – surgeon, anesthesiologist, radiologist, pathologist	100%	70%
Emergency Room Services Accidental Injury or Medical Emergency – Life-threatening medical conditions or serious Accidental Injuries. Initial services rendered for the onset of symptoms for a life-threatening medical condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm.	100%	100%
Non-Serious Accidental Injury or Non-Medical Emergency	100%	70%
Professional Ambulance Service (when Medically Necessary) Must be provided by a state-licensed emergency vehicle which carries, via the public streets, injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.	100%	100%

<table>
<tr><th>Summary of Benefits</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td colspan="3">Mental Health Services</td></tr>
<tr><td>Hospital Inpatient Services
Hospital Inpatient Services
Physician Hospital Services
Outpatient Treatment
Percentage payable per visit (unless otherwise specified)</td><td>100%

100%</td><td>70%

70%</td></tr>
<tr><td colspan="3">Physician and Professional Services</td></tr>
<tr><td colspan="3">Outpatient Pre-Certification is required for specified procedures</td></tr>
<tr><td>Physician Office Visit
Lab
X-ray
Surgery and professional services performed in the office
Allergy care – includes testing, serum and shots</td><td>100%</td><td>70%</td></tr>
<tr><td>Preventive Health Care Services

Percentage Payable – In-Network services not subject to the Deductible
The following services may be performed by a Physician or specialist Physician.
<u>Covered Services include but are not limited to:</u>

Preventive Services for Children Age 5 and Under
The Deductible does not apply to child wellness services (both In- and Out-of-Network) for children through age 5.
Services include but are not limited to:
Periodic Health Assessments
Well care office visits and associated x-ray and lab services
Development assessment of the child
Immunizations:
H. Influenza type b
Influenza (flu shot)
Pneumococcal Conjugate (pneumonia)
Tetanus, Diphtheria, Pertussis (DTaP)
Measles, Mumps, Rubella (MMR)
Hepatitis A
Hepatitis B
Varicella (chicken pox)
Polio
Screening Services:
Vision
Hearing
Lead level</td><td>

100%</td><td>

70%</td></tr>
</table>

Summary of Benefits	In-Network	Out-of-Network

Preventive Health Care Services (Cont'd)
Preventive Services for Children over Age 5 and Adults
(Eligible In-Network services not subject to the Deductible)
Services include but are not limited to:
• Periodic Health Assessments
• Physical exam
• Well care office visits and associated x-ray and lab services
• **Immunizations:**
  ◦ Influenza (flu shot)
  ◦ Pneumococcal Conjugate (pneumonia)
  ◦ Tetanus, Diphtheria (Td)
  ◦ Measles, Mumps, Rubella (MMR)
  ◦ Hepatitis A
  ◦ Hepatitis B
  ◦ Varicella (chicken pox)
  ◦ Meningococcal
  ◦ Meningococcal Polysaccharide
  ◦ Rotavirus
  ◦ Human Papilloma Virus (HPV)
• **Screening Services:**
  ◦ Colorectal cancer (fecal occult blood)
  ◦ Colorectal cancer (flexible sigmoidoscopy)
  ◦ Colorectal cancer (colonoscopy)
  ◦ Colorectal cancer (air contrast barium enema)
  ◦ Type II Diabetes (blood glucose test for high-risk individuals such as hypertension)
  ◦ Cholesterol
  ◦ Lipid
  ◦ HIV testing
• **Screening Services for Males:**
  ◦ Prostate cancer (digital rectal examination)
  ◦ Prostate cancer (prostate specific antigen)
• **Screening Services for Females:**
  ◦ Breast exam
  ◦ Osteoporosis (bone density)
  ◦ Routine pelvic, pap test, and contraceptive management
  ◦ Mammogram
  ◦ Chlamydia Test (as part of routine pelvic exam)
  ◦ Ovarian Surveillance
	100%	70%

Maternity Services Includes Physician pre-and post-natal care and delivery	 100%	 70%

Summary of Benefits	In-Network	Out-of-Network
Physical Therapy/Occupational Therapy Maximum visits per calendar year, combined specialties (In- and Out-of-Network combined)	 100% 20	 70% 20
Skeletal Adjustment (by any covered Provider)	100%	70%
Speech Therapy Maximum visits per calendar year (In-Network and Out-of-Network combined)	 100% 20	 70% 20
Respiratory Therapy	100%	70%
Radiation Treatment/Chemotherapy	100%	70%
Telemedicine/Teleradiology Services	100%	70%
Other Services		
Skilled Nursing Facility **Not Subject to Deductible** First 10 days Remaining 50 days Maximum days per calendar year (In-Network and Out-of-Network combined)	 100% 100% 60	 70% 70% 60
Home Health Care Services (not subject to Deductible) First 15 visits Remaining 25 visits Maximum visits per calendar year (In-Network and Out-of-Network combined)	 100% 100% 40	 70% 70% 40
NOTE: Covered Services available under Home Health Care do not reduce outpatient therapy benefits available under the Physical, Occupational or Speech Therapy sections shown in this Contract.		
Hospice Care Services (not subject to the Deductible)	100%	70%
Durable Medical Equipment (When Medically Necessary) Some items require pre-certification and/or prior approval	100%	70%
Wigs (when Medically Necessary)	100%	70%
Prescription Drugs 30-day supply (retail Participating pharmacy)	100%	70%
Note: A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a Prescription Drug requires pre-authorization, please call Customer Service. If a non-participating pharmacy is used, the Member must file a claim for reimbursement; the Member may be responsible for the difference between the Maximum Allowed Amount and the pharmacy's actual charge.		
All Other Covered Medical Expenses	100%	70%

Verification of Benefits

Verification of Benefits is available for authorized healthcare Providers on behalf of Members. You may call Customer Service with a **benefits inquiry** or **Verification of Benefits** during normal business hours (7:30 a.m. to 7:00 p.m. eastern time). Please remember that a **benefits inquiry** or **Verification of Benefits** is **Not** a Verification of Coverage of a specific medical procedure.

- **Verification of Benefits is Not a guarantee of payment.**
- **If the verified service requires pre-certification, please call 1-877-417-3363**

Pre-Admission Certification (PAC) ______ Required

- Required for **ALL** Hospital admissions except emergency or maternity delivery admissions.
- Please notify us within 48 hours of an emergency or maternity admission.
- Pre-Admission Certification (PAC) determinations are available by phone through American Health Holding (AHH) pre-certification staff 24 hours a day, seven days a week for urgent/non-elective care that must be performed within 24 hours after the PAC request, without which a significant threat to the patient's health or well-being will be posed.
- Non-urgent/elective pre-certifications can be requested during normal business hours (8:30 a.m. – 5:00 p.m. eastern time).
- The phone number for pre-certification is **1-877-417-3363.**
- Emergency services do **NOT** require pre-certification.

PAC is a guarantee of payment as described in this section (and BCBSGA will pay up to the reimbursement level of this Contract when the Covered Services are performed within the time limits assigned by PAC) **except the following situations:**

- The Member is no longer covered under this Contract at the time the services are received;
- The benefits under this Contract have been exhausted (examples of this include day limits or maximum amounts);
- No benefits will be paid in cases of fraud.

Pre-certification approvals apply only to services which have been approved in the pre-certification process and only as described in the approval. Such approval does not apply to any other services. Payment or authorization of such a service does not require or apply to payment of claims at a later date regardless of whether such later claims have the same, similar or related diagnoses.

Types of Coverage

Your type of coverage is determined by your selection at the time of enrollment through the Group.

Note: These benefits are valid for your Group's current Contract period. You will receive a revised Summary of Benefits if there is a change in your Group benefits.

NOTICE: The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Summary Notice and Important Phone Numbers/Website

This Certificate Booklet summarizes your employer's health care benefit program. This Certificate Booklet is written in an easy-to-read language to help you and your Dependents understand your health care benefits. It is issued as part of your employer's Group Master Contract and governs your Group's coverage.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate Booklet carefully. If you have any questions about your benefits as presented in this Certificate Booklet, please contact your employer's Employee benefit specialist or call the Customer Service Department.

This Certificate Booklet is an integral part of your employer's Group Master Contract. Its purpose is to help you understand your coverage and to provide an explanation of certain other benefits that your employer may offer. Certain administrative details and legal rights provisions are included in a separate document which is held by your employer.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción. *English translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your ID card or in your enrollment booklet.*

Pre-Admission Certification (PAC)
The Hospital, your Physician or You should call:

- 1-877-417-3363

Customer Service
If you have a customer service question, providers should call:

- 1-800-441-2273

Mental Health Care or Substance Abuse Treatment
You may access the mental health network in complete confidence by calling:

- 1-800-417-3363

BlueCard POS
If you are out of state and need service, simply dial this number:

- 1-800-810-2583

360° Health
For discounts and health information, please log on to the Member Access page at: www.bcbsga.com

Special Phone Numbers
Please check your ID Card for telephone numbers unique to your Group coverage.

About Health Savings Accounts

This high Deductible policy is designed to be a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts. This Contract may qualify you to make a pre-tax annual contribution to a Health Savings Account (HSA). NOTICE: Blue Cross and Blue Shield of Georgia does NOT provide tax advice. The Georgia Insurance Department does NOT in any way warrant that this policy meets the federal requirements.

The high Deductible Plan is not a "health savings account" or an "HSA", but is designed as an "HSA compatible high Deductible health Plan" that may allow you, if you are an eligible individual, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the Deductible under this Contract.

NOTICE: BCBSGA does not provide tax advice. If you intend to purchase this Contract to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

BCBSGA has designated this Contract to meet government requirements for an HSA compatible high Deductible health Contract to be used in conjunction with establishing eligibility for HSA tax benefits. Although BCBSGA believes that the Contract meets these requirements, the Internal Revenue Service has not ruled on whether the Contract is qualified as an HSA compatible high Deductible health Contract.

Should you purchase this Contract in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Contract does not qualify as a high Deductible health Contract, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.

Eligibility

This health program contains a 12-month pre-existing condition waiting period for Members age 19 and over except for maternity benefits. If a Member enrolls within 31 days of being eligible and has 12 months of prior Creditable Coverage with no significant break in coverage, the pre-existing condition waiting period will not apply. Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Eligible Employees Include:

- All Active Full-Time Employees of a Participating Employer;
- Surviving spouses until attainment of age 65 or marriage; and
- Eligible surviving children until attainment of limiting age.

Coverage for You

This booklet describes the benefits you may receive under your health care program. You are called the Subscriber or Member.

Coverage for Your Dependents

If you are covered by this program, you may enroll your eligible Dependents. Your Covered Dependents are also called Members.

If the wrong birth date of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Any overpayments made for coverage for any child under these conditions will be refunded by either you or BCBSGA.

Your Eligible Dependents Include:

- Your wife or husband (spouse);
- Your Dependent children through the end of the month in which they attain age 26, legally adopted children from the date you assume legal responsibility, children for whom you assume legal guardianship and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree.
- Children who are mentally or physically handicapped and totally dependent on you for support, regardless of age, with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Contract or prior Creditable Coverage prior to reaching age 26. Certification of the handicap is required within 31 days of attainment of age 26. A certification form is available from your employer or from the Plan Administrator and may be required periodically but not more frequently than annually after the two year period following the child's attainment of the limiting age.

If you and your spouse are both Employees of the same Employer, both of you may elect coverage, but only one may elect to have Dependent coverage.

Please note: For the purpose of this Contract, a spouse is the Subscriber's legal spouse as recognized by the State of Georgia.

Initial Enrollees

Initial Enrollees and eligible Dependents who were previously enrolled under Group coverage which this Contract replaces are eligible for coverage on the Effective Date of this coverage. Any employer or pre-existing exclusion waiting periods which were not satisfied under previous Creditable Coverage must be satisfied under this Contract. However, credit will be given for the length of time already served.

New Hires
Applications for enrollment must be submitted within 31 days from the date you are eligible to enroll as set by the employer. Applications for membership may be obtained from your employer. Your coverage will be effective based on the waiting period chosen by your employer. If you or your Dependents do not enroll when first eligible, you will be treated as a Late Enrollee. Please refer to the **"Late Enrollees"** provision listed below.

Late Enrollees
If you or your Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, you may be eligible for special enrollment as set out below.

Special Enrollment Periods
There are special enrollment periods for Employees or Dependents who:

- Originally declined coverage because of other coverage, and
- Who exhausted COBRA benefits, lost eligibility for prior coverage, or employer contributions toward coverage were terminated.
- An individual who declined coverage must have certified in writing that they are covered by another health program when they initially declined coverage under this Group in order to later qualify under this special enrollment. Persons declining coverage will be given notice of the consequences when they originally decline coverage.

In addition, there are also special enrolment periods for new Dependents resulting from marriages, births or adoptions. Dependents must be enrolled within 31 days of the birth, date of marriage, or date of adoption or placement for adoption. For Dependents age 19 and over, a twelve (12) month pre-existing waiting period will apply if enrollment does not occur within 31 days.

<u>Important Notes:</u>

- Individuals enrolled during special enrollment periods are **not** Late Enrollees and are subject to the normal 12 month pre-existing condition requirements unless under age 19 or enrolled under prior Creditable Coverage (excluding newborns, adoptions and pregnancies).
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- Evidence of prior Creditable Coverage is required and must be furnished by you or your prior carrier.

Medicaid and CHIP Special Enrollment/Special Enrollees
Eligible Employees and Dependents may also enroll under two additional circumstances:

- The Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Your Coverage Begins
If you apply when first eligible, your coverage will be effective on the first of the month following the date your Participating Employee's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision your employer requires; however, you will receive credit toward your pre-existing condition waiting period for any Employee length-of-service requirement which you must serve.

Changing Your Coverage
There may be an annual re-enrollment period during which time Members may elect to change their options. Employees and Dependents enrolled in another option may be required to complete an unfulfilled waiting period from prior Creditable Coverage.

Types of Coverage
The types of coverage available to you are indicated at the time of enrollment through the Group.

For the purpose of this Contract, a spouse is defined as a person of the opposite sex from that of the enrolling Subscriber.

Changing Your Coverage (Adding a Dependent)
You may add new Dependents to your Contract by contacting your Plan Administrator. You must notify the Plan Administrator in writing. The Plan Administrator is the person named by your employer to manage the program and answer questions about program details.

Coverage is provided only for those Dependents you have reported to your employer and added to your coverage by completing the correct application.

Marriage and Stepchildren
A Member may add a spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the first of the month following the date of marriage. Remember, there will be an additional charge.

If a Member does not apply for coverage to add a spouse and stepchildren within 31 days of the date of marriage, the spouse and stepchildren are considered Late Enrollees. Please refer to the **"Late Enrollees"** provision in this section.

Newborn and Adopted Children
A newborn or an adopted child is covered automatically for 31 days from the moment of birth or date of assumption of legal responsibility. If additional Premium is required to continue coverage beyond the 31-day period, the Member must notify the Plan Administrator of the birth or adoption and pay the required Premium within the 31-day period or coverage will terminate. Types of coverage requiring additional Premium include One-Person Coverage and Two-Person Coverage.

If a Member has Family Coverage or Multi-Person Coverage, no additional Premium is required and coverage automatically continues. However, the Member should notify the Plan Administrator of the birth or adoption within 31 days to ensure accurate records and timely payment of claims.

Extending coverage for a newborn child or an adopted child being added to One-Person or Two-Person Coverage beyond the 31-day period requires late enrollment. Please refer to the **"Late Enrollee"** provision in this section.

Foster Children
Foster children are children of those whose parental rights have been terminated by the state and who have been placed in an alternative living situation by the state. A child does not become a foster child when the parents voluntarily relinquish parental power to a third party.

Foster children for whom a Member assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, a Member must provide confirmation of a valid foster parent relationship to the Plan Administrator. Such confirmation must be furnished at the Member's expense. When the application is processed, the Effective Date will be the date legal responsibility is assumed.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final. Pre-existing condition limitations will not apply to children under age 19 as long as the adoption (or placement for adoption) occurs while the Employee is eligible for coverage.
    - An "adopted child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received a MCSO (a "Medical Child Support Order") which has been determined by the employer or Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO").
    - Upon receipt of an MCSO, the employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave

For groups with 50 or more Employees, if a covered Employee ceases active employment due to an employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Your Coverage or Removing a Dependent

When any of the following events occur, notify your employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family
  Member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see "When Your Coverage Terminates");
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work

Initial Enrollees

After a group takeover, if a Member (or a Dependent) had coverage under a prior carrier and is now covered under an extension of benefits provision, the Member (or Dependent) will be enrolled for coverage under this Contract. However, the prior carrier's extension of benefits provision makes the prior carrier responsible for payment of benefits and services relating to disabilities in accordance with the terms of its coverage and state law. To the extent benefits and services are not covered by the prior carrier's extension of benefits provision, payment will be made under this Contract in accordance with the ordinary Contract rules covering such benefits and services.

New Hires
Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Group but not currently active due to health status.

Portability Provision
Any newly eligible Employee, Member, Subscriber, enrollee, or Dependent who has had similar coverage under another health benefit plan within the previous 90 days is eligible for coverage immediately. The Effective Date of coverage is subject to any length-of-service provision your employer requires; however, any pre-existing condition waiting period will run concurrently. A newly eligible person is an individual who was not previously eligible for coverage under the Group Contract. There is a 12 month pre-existing condition waiting period for Members age 19 and over imposed following the Enrollment Date of coverage; however, this period is waived to the extent that an individual had prior Creditable Coverage.

Certification of Prior Creditable Coverage
If your coverage is terminated, you and your Covered Dependents will automatically receive a certification showing when you were covered under the Plan. You may need the document to qualify for another group health plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. Certification may be requested within 24 months of losing coverage. If you have any questions, contact customer service at the telephone number listed on the back of your Identification Card.

How Your Benefits Work For You
Note: Capitalized terms such as Covered Services, Medical Necessity, In-Network Provider and Out-of-Pocket Limit are defined in the "Definitions" Section.

Introduction
Your Point of Service (POS) Health Contract is a comprehensive program. The Contract is divided into two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will receive In-Network benefits. Utilizing this method means you will not have to pay as much money; your Out-of-Pocket expenses will be higher when you use Out-of-Network Providers.

Providers are compensated using a variety of premium arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Calendar Year Deductible
Unless otherwise indicated, before your program begins to pay benefits you must meet any Deductible required. Deductible requirements are stated in the **Summary of Benefits**.

Coinsurance and Out-of-Pocket Limit
The percentage payable by BCBSGA is stated in the **Summary of Benefits**. The portion which you must pay (the **Coinsurance**) is stated in the **Summary of Benefits**. After you reach your Out-of-Pocket Limit, your Contract pays 100% of the Maximum Allowable Amount for the remainder of the Calendar Year.

Consumer Choice Option – (Please note the following applies only if you purchased the Consumer Choice Option at enrollment)
The Consumer Choice Option allows you to nominate an Out-of-Network Provider (limited to a Physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advance practice nurse, registered optician, licensed professional counselor, physical therapist, licensed marriage and family therapist, chiropractor, qualified athletic trainer (per OCGA 43-5-8), occupational therapist, speech language pathologist, audiologist, dietician, Physician's assistant or Hospital) for specified Covered Services. Such nominated Providers must be approved in writing by BCBSGA and are subject to the normal rules and conditions which apply to a contracted In-Network Provider. These terms include reimbursement (who we pay and how much), utilization management protocols (pre-certification procedures and our internal procedures enabling us to pay for Covered Services), Prescription Drug Formulary compliance (making sure we pay for drugs on our approved list), referral to In-Network or Out-of-Network Providers, and other internal procedures which BCBSGA normally follows. All Out-of-Network Providers must be nominated, agree to participate and be approved.

Please remember that, while you may obtain benefits at In-Network levels from an approved, nominated Provider, these Providers have not gone through BCBSGA's rigorous credentialing process, and they are not subject to BCBSGA's quality assurance standards.

The nominated Provider is not an In-Network Provider (Preferred Provider) and has not been credentialed by BCBSGA. The Member alone is responsible for the selection of the nominated Provider and BCBSGA has not undertaken any credentialing or quality assurance measures regarding such nominated Provider, BCBSGA will not undertake to conduct routine quality assurance measures which are used for In-Network Providers (Preferred Providers). The Member should understand that any and all Physicians, Hospitals and any others who are not In-Network Providers (Preferred Providers) must be nominated by the Member (patient) and approved by BCBSGA prior to any services being performed

by the Provider in order for the services to become eligible for Reimbursement at In-Network benefit levels.

For additional information, please contact your Plan Administrator.

Provider Nomination
Under the Consumer Choice Option, you may nominate any Hospital or Provider listed above licensed to practice in the state of Georgia to render specified Covered Services. However, you do not have free unrestricted access to non-nominated Providers or to Providers who have been nominated by you but not yet approved by BCBSGA.

The nomination process includes several steps:
1. You may obtain copies of the nomination form by calling 1-800-441-2273.
2. Complete and sign the first section of the nomination form and give to your Provider.
3. The Provider signs the second part of the form, indicating they may be interested in acting as your Provider, subject to BCBSGA's terms and conditions. The Provider requests authorization for specific procedures (or ongoing medical treatment). The Provider submits the form to BCBSGA.
4. BCBSGA verifies the licensure of the Provider and notifies the Provider of the applicable fee schedule or potential reimbursement.
5. The Provider after receiving the notice of the potential reimbursement signs and returns the form to BCBSGA.
6. BCBSGA notifies you and your Provider if and when the fully completed form has been received and approved.

A decision will be made by BCBSGA within 3 days of the receipt of the fully completed nomination form. Please note that approval is made only for the requested procedures. Additional procedures must be requested and approved by BCBSGA.

It is important to remember that only after all these steps and all other Contract requirements have been followed are Covered Services paid when provided by a Non-Network Provider (Non-Preferred Provider).

What your Program Pays

Introduction: All defined terms are capitalized and can be found in the Definitions section of this booklet.

In order to assist you in understanding the Maximum Allowed Amount language as described below, please refer to the definition of In-Network Provider, Out-of-Network Provider and Non-Preferred Provider contained in the Definitions section of this booklet.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this plan's Maximum Allowed Amount for the Covered Service you receive. Please see the BlueCard POS section for additional information.

The Maximum Allowed Amount for this plan is the maximum amount of reimbursement BCBSGA will pay for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charge. This amount can be significant.

When you receive Covered Services from an eligible Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network or Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific plan or in a special Center of Excellence/or other closely managed specialty network, or who has a participation Contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this plan is the rate the Provider has agreed with BCBSGA to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for that service, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit www.bcbsga.com.

Providers who have not signed any Contract with us and are not in any of our networks are Out-of-Network Providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this plan will be one of the following as determined by BCBSGA:

1. An amount based on our Out-of-Network fee schedule/rate, which we have established at our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with BCBSGA, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this product, but are contracted for our indemnity product are considered Non-Preferred. For this plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the Contract between us and that Provider specifies a different amount. In this case Non-Preferred Providers may not send you a bill and collect for the amount of the Non-Preferred Provider's charge that exceeds our Maximum Allowed Amount for Covered Services.

Unlike In-Network Providers or Non-Preferred Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower Out-of-Pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit our website at www.bcbsga.com.

Customer Service is also available to assist you in determining your plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network or Non-Preferred Providers. Please see the Summary of Benefits section in this Certificate Booklet for Your cost share responsibilities and limitations, or call Customer Service to learn how this plan's benefits or cost share amounts may vary by the type of Provider You use.

BCBSGA will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by your Provider for Non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Both services specifically excluded by the terms of your policy/plan and those received after benefits have been exhausted are Non-Covered Services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Example: Your plan has a Coinsurance cost share of 20% for In-Network services, and a 30% Out-of-Network after the in or out of network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the services is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; Your Coinsurance responsibility is 20% of $950, or $190 and the remaining allowance from us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, your total Out-of-Pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.
- You choose an In-Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total Out-of-Pocket responsibility would be $300.

- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery is $1500; your Coinsurance responsibility for the Out-of-Network surgeon is 30% of $1500, or $450 after the Out-of-Network Deductible has been met. We allow the remaining 70% of $1500, or $1050. In addition, the Out-of-Network surgeon could bill you the difference between $2500 and $1500, so your total Out-of-Pocket charge would be $450 plus an additional $1000, for a total of $1450.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Services, we may authorize the In-Network cost share amounts (Deductible, Copayment and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Covered Service so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Example:
You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your plan has a $45 Copayment for Out-of-Network Providers and a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500 and the Maximum Allowed Amount is $200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and BCBSGA will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your In-Network Copayment of $25, your total Out-of-Pocket expense would be $325.

Pre-Admission Certification (PAC) and Outpatient Pre-Certification

Hospital Pre-Certification

PAC is a requirement for both In-Network and Out-of-Network benefits.

The Pre-Admission Certification Process

- Length-of-Stay Assignment indicates the number of Inpatient days usually Medically Necessary to treat a condition;
- Continued Stay Review/Concurrent Review to determine whether a continued Inpatient stay is Medically Necessary;
- Admission Review to determine whether an unscheduled Inpatient admission or an admission not subject to pre-certification was Medically Necessary;
- Discharge Planning to assess the Member’s need for additional treatment after Hospital discharge.

In-Network Care

- If you are hospitalized other than for an emergency or maternity delivery admission and Pre-Admission Certification was not obtained, all charges will be denied. You will be held harmless if all network guidelines are followed and you were admitted to an In-Network Hospital. This means you will not be responsible for any bill in excess of the related Deductible, Coinsurance that applies, and Non-Covered Services.

  If your stay exceeds the number of days assigned under this program, the Hospital’s charge for additional days beyond the assigned Length-of-Stay will not be paid. If all In-Network guidelines are followed, you will not be responsible for any Covered Services except the normal Deductible, Coinsurance and Non-Covered Services.
- Ineligible Charges and Non-Covered Services are always the Member’s responsibility.
- PAC is the responsibility of the In-Network Hospital or In-Network Physician.

Out-of-Network Care

- You, the Physician or the Hospital **must** obtain approval for all Hospital admissions except for emergency or maternity delivery admissions.
- If you are hospitalized other than for an emergency or maternity delivery admission and Pre-Admission Certification was not obtained, all charges will be denied. You – the Member – will be responsible for the Hospital’s charges in addition to any Deductible, Copayment, or Coinsurance, and Non-Covered Services which may apply.
- If you obtained PAC but exceed the number of days allowed through the PAC process, you will be responsible for all of the charges for those days.

If you are admitted to an Out-of-Network Hospital and the admission is determined not to be Medically Necessary, all charges for that admission and related Physician charges will be Ineligible Charges. Out-of-Network Providers are under no obligation to hold you harmless for those charges, so you may be responsible for the full amount of all of those charges.

Ineligible Charges are always the Member’s responsibility.

Pre-Admission Certification is NOT a guarantee of payment. Admissions are approved only when the appropriateness of the Inpatient setting can be substantiated. Actual payment is based upon eligibility for coverage and the Effective Date for any Member and also will be dependent on, but not limited to, specific Group coverage and the status of the coverage on the date services are rendered. The program will not cover services related to specific Contract exclusions and limitations, including but not limited to, Custodial Care, Experimental and Investigational procedures, pre-existing conditions during the waiting period and services determined not Medically Necessary.

Outpatient Pre-Certification Requirements

Your Contract provides Covered Services when outpatient services are Medically Necessary. Certain outpatient procedures require pre-certification from AHH. Such services include, but are not limited to, outpatient surgical procedures, diagnostic imaging procedures, and Durable Medical Equipment. This outpatient pre-certification is a requirement for both In-Network and Out-of-Network benefits.

Pre-certification is required for the following outpatient procedures:

- CT Scan (Computed Tomography Scan)
- CTA
- Dialysis
- Echocardiography
- Home Health Care
- Hospice
- Hysterectomy (under age 35)
- MRA
- MRI
- Nuclear Cardiology
- Orthognathic/TMJ
- PET
- Reconstructive Surgery
- Skilled Nursing
- Sleep Studies
- Transplant Evaluations – Call (877) 417-3363 or fax (614) 818-3236
- UPPP

All scans (CT, CAT, MRI, PET, etc.) require Pre-certification through American Imaging Management (AIM). The provider of services may obtain Pre-certification by calling (866) 714-1103.

This list is subject to change. Please call the number on your ID card to determine if a particular procedure or item requires pre-certification.

Benefits

Payment terms apply to all Covered Services. The following services are applicable to In-Network and Out-of-Network benefits.

All Covered Services must be Medically Necessary, whether provided through In-Network Providers or Out-of-Network Providers.

Ambulance Service
Local service to a Hospital in connection with care for a Medical Emergency or if otherwise Medically Necessary. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

Anesthesia Services for Certain Dental Patients
General anesthesia and associated Hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:

- Patients age 7 or younger or developmentally disabled;
- An individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder;
- An individual who has sustained extensive facial or dental trauma, except for a Workers' Compensation claim.

Pre-certification is required.

Assistant Surgery
Services rendered by an assistant surgeon are covered based on Medical Necessity.

Breast Cancer Patient Care
Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery
Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Cardiac Rehabilitation
Programs require prior authorization and individual case management.

Clinical Trial Programs for Treatment of Children's Cancer
Covered Services include routine patient care costs incurred in connection with the provision of goods, services, and benefits to Members who are Dependent children in connection with approved clinical trial programs for the treatment of children's cancer. Routine patient care costs mean those Medically Necessary costs as provided in Georgia Law (OCGA 33-24-59.1).

Colorectal Cancer Examinations and Laboratory Tests
Covered Services include colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening.

Complications of Pregnancy
Benefits are provided for Complications of Pregnancy (see "Definitions"), resulting from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy. Benefits for a normal or difficult delivery are not covered under this provision. Such benefits are determined solely by the maternity section if maternity is listed as covered in this booklet.

Consultation Services
Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered and payable at regular Contract benefits.

Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Contract.

Diabetes
Equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes are prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

Dialysis Treatment
Dialysis treatment is covered for care when pre-certification approval has been obtained from AHH. BCBSGA will pay secondary to Medicare part B, after 30 months, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment
This program will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable pre-certification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the patient's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. AHH may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the patent's physical disorder.

Emergency Room Services/Emergency Medical Services
Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for an emergency medical condition or serious Accidental Injury which requires immediate medical care.

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

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

General Anesthesia Services
Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:
- Spinal or regional anesthesia;
- Injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are also covered.

Home Health Care Services
Home Health Care provides a program for Member's care and treatment in the home. Your coverage is outlined in the Summary of Benefits. A visit consists of up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either In-Network or Out-of-Network Providers.

Some special conditions apply:
- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis.
- A Member must be essentially confined at home.

Covered Services:
- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical, Occupational or Speech Therapy section shown in this Contract.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:
- Food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- Services and/or supplies which are not included in the Home Health Care plan as described;
- Services of a person who ordinarily resides in the patient's home or is a Member of the family of either the patient or patient's spouse;

- Any services for any period during which the Member is not under the continuing care of a Physician;
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient;
- Any services or supplies not specifically listed as Covered Services;
- Routine care and/or examination of a newborn child;
- Dietitian services;
- Maintenance therapy;
- Dialysis treatment;
- Purchase or rental of dialysis equipment;
- Private duty nursing care.

Hospice Care Services
Hospice benefits covered Inpatient and Outpatient services for patients certified by a Physician as terminally ill with a life expectancy of six months or less.

Your Contract provides Covered Services for Inpatient and Outpatient Hospice care as stated in the **Summary of Benefits**. The Hospice treatment program must:

- Be recognized as an approved Hospice program by BCBSGA;
- Include support services to help covered family Members deal with the patient's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that;
- Provides an organized system of home care;
- Uses a Hospice team; and
- Has around-the-clock care available.

To qualify for Hospice care, the attending Physician must certify that the patient is not expected to live more than six months. Also, the Physician must design and recommend a Hospice Care Program. The Physician's statement and recommended program must be pre-authorized.

Hospital Services
You may receive treatment at an In-Network or Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Contract provides Covered Services when the following services are Medically Necessary.

In-Network

Inpatient Hospital Services

- Inpatient room charges. Covered services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, Covered Services are based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that has only private rooms, Covered Services are based on the Hospital's prevalent room rate. Pre-certification is required for all Hospital admissions.

Service and Supplies

- Services and supplies provided and billed by the Hospital while you're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitor's meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity

Outpatient Hospital Services

- Your Contract provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic x-rays and similar services. Certain outpatient procedures require pre-certification from AHH.

Out-of-Network

Inpatient/Outpatient Hospital Benefits

- If you are confined in an Out-of-Network Hospital or receive covered outpatient services, your benefits will be significantly reduced, as explained in the **"How Your Benefits Work For You"** section. Pre-Certification is required for all Hospital admissions and certain outpatient procedures.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each Physician during the covered period of confinement.

Individual Case Management

The individual case management program is designed to ensure and provide payment of benefits to eligible Members who, with their attending Physician, agree to treatment under an alternative benefit plan intended to provide quality health care under lower cost alternatives. Such benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each program participant.

The program includes:

- The identification of potential program participants through active case finding and referral mechanisms;
- Eligibility screening;
- Preparation of alternative benefit plans;
- Subsequent to the approval of the parties, transfer to alternative treatment settings in which quality care will be provided.

Eligibility

A Member receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Contract benefits.

AHH is responsible for determining eligibility for cases to be included in the program.

The Member – or legal guardian or family Member, if applicable – and the attending Physician must consent to explore with AHH the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

Benefits

Benefits will be determined on a case-specific bases, depending on the plan of treatment, and may include Covered Services under the applicable Contract.

Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is less expensive than the original treatment plan which otherwise would have been followed. AHH will determine the approved payments services allowable under the program.

Benefits under the program are furnished as an alternative to other Contract benefits and are limited to the following:

- Services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Member.
- Non-structural modifications to the home which are required to meet minimum standards for safe operation of equipment.
- When necessary for the long term care of the Member in the home-setting, Respite Care to relieve family Members or other persons caring for the Member at home. (The Respite Care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. AHH may approve on an exception basis up to 5 days per month of Respite Care when medical review of the case indicates that such action is appropriate. Payments for Respite Care will be deducted from the Member's remaining available benefits under the program.)

The Member must obtain pre-certification from AHH regarding the treatment plan and proposed setting to be utilized during the Respite Care period.

Potential cases include but are not limited to:

- Spinal cord Injury;
- Severe head trauma/coma;
- Respiratory dependence;
- Degenerative muscular/neurological disorders;
- Long term IV antibiotics;
- Premature birth;
- Burns;
- Cardiovascular accident;
- Cancer;
- Accidents;
- Terminal illnesses;
- Other cases at AHH's discretion.

<u>Covered Services</u>

- Services covered under individual case management will be determined by AHH, in our sole discretion on a case-by-case basis. Benefits may be provided for the rehabilitation of a Member on an Inpatient, Outpatient, or out-of-Hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.
- The program may provide or coordinate any of the types of Covered Services provided pursuant to this Certificate Booklet.
- In its sole discretion, in the context of an individual case management program, AHH may also provide or arrange for alternative services or extra-contractual benefits which are either (i) excluded by this Certificate Booklet; (ii) neither excluded nor defined as Covered Services under this Certificate Booklet; or (iii) exceeding the maximum for any Covered Service under this Certificate Booklet.

<u>Utilization</u>

- Benefits will be provided only when and for as long as AHH deem they are Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long, and shall be subject to pre-certification and continuing review for Medical Necessity as set forth in such plan for treatment.
- The total benefits paid under this program will not exceed those which the Member would otherwise have received in the absence of individual case management benefits.

Exclusions

- Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in our sole discretion, significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the individual case management program.

Individual Case Management Definitions

Case Manager

The person designated by us to manage and coordinate the Member's medical benefits under the individual case management program. The Case Manager's role is determined by AHH.

Provider

A Provider may be any facility or practitioner, including but not limited to Ineligible Providers, licensed or certified to give services or supplies consistent with the Plan of Treatment and approved by AHH.

Termination of Individual Case Management

Services in the alternative benefit plan approved by AHH under individual case management will cease to be Covered Services under this Contract when extra-contractual benefits or alternative services are no longer Medically Necessary, as determined by AHH due to a change in the patient's condition.

Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician as outlined in the **Summary of Benefits**. Developmental Delay will be covered when it is more than two standard deviations from the norm as defined by standardized, validated developmental screening tests such as the Denver Developmental Screening Test. Services will be covered only to treat or promote recover of the specific functional deficits identified.

Maternity Care

Covered Services for Maternity Care are stated in the **Summary of Benefits**.

Maternity benefits are provided for a female Employee or for the spouse of a male Employee. Maternity benefits are not provided for Dependent children.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing You Coverage" to add a newborn to your coverage.)

Under federal law, the Contract may not restrict the length of stay to less than the 48/96-hour periods or require pre-certification for either length of stay. The length of Hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48- or 96- hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

Medical and Surgical Care

General care and treatment of illness or Injury, and surgical diagnostic procedures including the usual pre- and post-operative care.

Mental Health Care and Substance Abuse Treatment

Hospital Inpatient Care
Benefits for Inpatient Hospital and Physician charges are subject to the Deductible and Coinsurance requirements as shown in the **Summary of Benefits**.

Professional Outpatient Care
Benefits for outpatient charges are subject to the calendar year Deductible, Copayment and percentage payable provisions stated in the **Summary of Benefits**.

Covered Services include:
- Professional care in the outpatient department of a Hospital;
- Physician's office visits; and
- Services within the lawful scope of practice of a licensed approved Provider.

Note: To be reimbursable, care must be given by a psychiatrist, neuropsychologist, or a mid-level Provider such as a licensed clinical social worker, mental health clinical nurse specialist, a licensed marriage and family therapist, or a licensed professional counselor.

Mental Health Care or Substance Abuse Treatment may be obtained by calling 1-800-292-2879.

Nutritional Counseling
Nutritional counseling related to the medical management of a disease state (subject to pre-certification by AHH).

Nutritional Counseling for Obesity
Covered Services for obesity include up to two nutritional counseling visits when referred by your Physician. Prescription Drugs and any other services or supplies for the treatment of obesity are not covered.

Optometrist's Services
Services within the lawful scope of practice of and rendered personally by a licensed optometrist (O.D.), for which payment would be made under this Contract to a Physician providing the same services.

Oral Surgery
Pre-certification is required by AHH and must be obtained by the Member. Covered Services include only the following:
- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of Temporomandibular Joint Syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);

- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure.

Organ/Tissue/Bone Marrow Transplant

Covered Services include certain services and supplies not otherwise excluded in this Certificate Booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (Donor Costs), post-operative care (including antirejection drug treatment, if Prescription Drugs are covered under the Contract) and transplant related chemotherapy for cancer limited as follows:

A transplant means a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or
- Removed from and replaced in the same person's body (called a self-donor).

A covered transplant means a Medically Appropriate transplant.

- Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.
- Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, but **only** if required in the treatment of:
  - Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
  - Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
  - Neuroblastoma, Stage III or Stage IV;
  - Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have an HLA-compatible donor available for allogenic bone marrow support.
  - Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds.
  - Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
  - Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse.
- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:
  - Aplastic anemia;
  - Acute leukemia;
  - Severe combined immunodeficiency exclusive of acquired immune deficiency syndrome (AIDS);
  - Infantile malignant osteoporosis;
  - Chronic myelogenous leukemia;
  - Lymphoma (Wiscott-Aldrich syndrome);
  - Lysosomal storage disorder;
  - Myelodysplastic syndrome.

"Donor Costs" means all costs, direct and indirect (including program administration costs), incurred in connection with:

- Medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- Preserving it; and
- Transporting it to the site where the transplant is performed.

In the treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports.

For purposes of this benefit, the term transplant does not include transplant of blood or blood derivatives (except hematopoietic stem cells) which will be considered as non-transplant related under the terms of the Contract.

"Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and antirejection drugs.

"Medically Appropriate" means the recipient or self-donor meets the criteria for a transplant established by AHH.

"Professional Provider Transplant Services" means all Medically Necessary services and supplies provided by a professional Provider in connection with a covered transplant except Donor Costs and antirejection drugs.

Benefits for Antirejection Drugs
For antirejection drugs following the covered transplant, BCBSGA will pay according to the benefits for Prescription Drugs, if any, under the Contract.

Pre-certification Requirements
All transplant procedures must be pre-certified for type of transplant and be Medically Appropriate according to criteria established by AHH. To pre-certify, call the AHH office using the telephone number on your Identification Card.

The pre-certification requirements are a part of the benefit administration of the Contract and are not a treatment recommendation. The actual course of medical treatment the Member chooses remains strictly a matter between the Member and his or her Physician.

Your Physician must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be performed at a recognized transplant center. The donor, donor recipient and the transplant surgery must meet required medical selection criteria as defined by AHH.

If the transplant involves a living donor, benefits are as follows:
- If a Member receives a transplant and the donor is also covered under this Contract, payment for the Member and the donor will be made under each individual's coverage.
- If the donor is not covered under this Contract, payment for the Member and the donor will be made under this Contract but will be limited by any payment which might be made under any other Hospitalization coverage plan.
- If the Member is the donor and the recipient is not covered under this Contract payment for the Member will be made under this Contract limited by any payment which might be made by the recipient's Hospitalization coverage with another company. No payment will be made under this Contract for the recipient.

Please see the "Limitations and Exclusions" section for Non-Covered Services

Osteoporosis
Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Members meeting our criteria.

Other Covered Services

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, casts when provided by a Physician
- Oxygen, blood and components, and administration
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment

Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while you are a patient or receive services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at 70% of the Maximum Allowed Amount.

Outpatient CT Scans and MRIs

Pre-certification is required. These services will be subject to the Member's Deductible and Coinsurance regardless of the Provider setting – Physician's office or Hospital setting.

Outpatient Surgery

In-Network Hospital outpatient department or In-Network Freestanding Ambulatory Facility charges are covered at regular Contract benefits. These benefits are subject to both Deductible and percentage payable requirements. Benefits for treatment by an Out-of-Network Hospital are explained under "Hospital Services".

Ovarian Cancer Surveillance Tests

- Covered Services are provided for at risk women 35 years of age and older. At risk women are defined as: (a) having a family history (i) with one or more first or second-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, (iii) of nonpolysis colorectal cancer; or (b) testing positive for BRCA1 or BRCA2 mutations.
- Surveillance tests mean annual screening using: (a) CA-125 serum tumor marker testing, (b) transvaginal ultrasound, and (c) pelvic examinations.

Physical Therapy, Occupational Therapy, Chiropractic Care or Services of Athletic Trainers

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), licensed chiropractor (D.C.), or qualified athletic trainers, are limited per calendar year as outlined in the **Summary of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. Physical Therapy and Occupational Therapy will be provided for Developmental Delay.

Physician Services

You may receive treatment from a Preferred or Non-Preferred Physician. However, payment is significantly reduced if services are received from a Non-Preferred Physician. Such services are subject to your Deductible and Out-of-Pocket requirements.

Prescription Drugs

Coverage for Prescription Drugs is provided as outlined in the **Summary of Benefits**.

Preventive Care
Preventive care services include outpatient services and office services. Screenings and other services are covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition but instead benefits will be considered under the diagnostic services benefit.

Preventive care services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no Deductible, Copayments or Coinsurance from the Member when provided by an In-Network Provider. That means BCBSGA pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High Blood Pressure;
    - Type 2 Diabetes Mellitus;
    - Cholesterol;
    - Child and Adult Obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration

You may call Customer Service using the number on your ID card for additional information about these services. Information is also available at these federal government websites:

- http://www.healthcare.gov/center/regulations/prevention.html; or
- http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.

Covered Services also include services required by state and federal law as outlined in the **Summary of Benefits**.

Private Duty Nursing Services
Pre-certification of Medical Necessity is required from the Physician and must be confirmed by AHH.

Limitations for both Inpatient and Outpatient RN and LPN
- Eligible Charges for services of an RN or LPN, whether on an Inpatient our Outpatient basis, are limited to the calendar year maximum per Member as shown in the **Summary of Benefits**.
- Inpatient care is covered only when no intensive or cardiac care unit is available, and the care needed is beyond the capabilities of the Hospital’s floor nurses. Services may be performed by either an In-Network or Out-of-Network Provider.
- Eligible Charges do not include services when:

- Requested by, or for the convenience of, the patient or the patient's family;
- Services consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving oral medication, or acting as a companion or sitter;
- The private duty nurse is a relative by blood or marriage or Member of the household of the Member.
- Inpatient services could have been rendered by the Hospital's general nursing staff; or
- Outpatient services could be safely rendered by an individual other than a RN or LPN.

Prosthetic Appliances
Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); external breast prostheses used after breast removal.

The following items are **excluded**: corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); hearing aids or hearing devices; implants for cosmetic purposes except for reconstruction following a mastectomy.

Pulmonary Rehabilitation
Programs require prior authorization and Individual Case Management.

Reconstructive Surgery
Pre-certification is required. Reconstructive surgery does not include any services otherwise excluded in this Certificate Booklet (See "Limitations and Exclusions")

Reconstructive surgery is covered only to the extent Medically Necessary:

- To restore a function of any body area which has been altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes;
- To correct congenital defects of a Dependent child that lead to functional impairment; and
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Registered Nurse First Assistant
Covered Services are provided for eligible registered nurse first assistants. Benefits are payable directly to a registered nurse first assistant if such services are payable to a surgical first assistant and such services are performed at the request of a Physician and within the scope of a registered nurse first assistant's professional license. No benefits are payable to a registered nurse first assistant who is employed by a Physician or Hospital.

Skilled Nursing Facility Care
Benefits are provided as outlined in the Summary of Benefits. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the patient's residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this program pays the amount of the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and Radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient;
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for chronic brain syndromes for which no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Telemedicine

The practice of Telemedicine, by a duly licensed Physician or healthcare Provider, by means of audio, video or data communications (to include secured electronic mail) is a covered benefit.

The use of standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof does not constitute Telemedicine service and is not a covered benefit.

The use of Telemedicine may substitute for a face-to-face "hands on" encounter for consultation.

To be eligible for payment, interactive audio and video telecommunications must be used, permitting real-time communications between the distant Physician or practitioner and the Member/Patient. As a condition of payment, the patient (Member) must be present and participating.

The amount of payment for the professional service provided via Telemedicine by the Physician or practitioner at the distant site is based on the current Maximum Allowed Amount for the service provided. The patient (Member) is subject to the applicable Deductible and Coinsurance based upon his or her In-Network or Out-of-Network benefits.

Urgent Care Services

Covered Services rendered at contracted Urgent Care Centers are covered as outlined in the **Summary of Benefits**.

Prescription Drug Program

Under the program, you pay the Prescription Drug Coinsurance shown in the **Summary of Benefits** per prescription or prescription refill and PartnersRx pays the balance. For Prescription Drugs and diabetic supplies rendered by a pharmacy, the Maximum Allowed Amount is the amount determined by PartnersRx using Prescription Drug cost information provided by the pharmacy benefits manager.

At the time the prescription is dispensed, present your Identification Card at the participating pharmacy. The participating pharmacist will complete and submit the claim for you. If you do not go to a participating pharmacy, you will need to submit the itemized bill to be processed.

Benefits

The Prescription Drug Program provides coverage for drugs which, under federal law, may only be dispensed with a prescription written by a Physician. Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug Program when accompanied by a prescription.

This program allows for refills of a prescription within one year of the original prescription date, as authorized by your Physician.

A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires pre-authorization, please call Customer Service.

Covered Services may include:

Retail prescription medications that have been prescribed by a Network Provider and obtained through a participating pharmacy.

Specialty Drugs

Specialty Drugs are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Specialty Drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at retail pharmacies. Most Specialty Drugs require preauthorization. You may obtain the list of Specialty Drugs and contracted Network Specialty Pharmacies by contacting customer service.

You or your Physician may order your Specialty Drugs from a Network Specialty Pharmacy. The first time a Specialty Drug is ordered for home use you will be asked to complete a Patient Profile questionnaire. To obtain a Specialty Drug for home use, you must have a prescription for the drug which is signed by a Physician and which states the drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address. If the Specialty Drug is ordered via telephone, any Coinsurance due can be paid by credit card or debit card. When submitting a paper prescription, a completed order form is required along with your Coinsurance payable by check, money order, credit or debit card.

Network Specialty Pharmacies will deliver your Specialty Drug prescriptions via common overnight carrier and are shipped directly to your or, if necessary, to a Network Provider for administration. Your treatment plan and specific prescription will determine where administration of the drug will occur and by whom. In order to better support your treatment plan, Specialty Drug prescriptions that exceed 30 days may be dispensed in more than one shipment. When this occurs, please note that your total cost for multiple shipments will not exceed the amount you would have incurred for a single shipment.

Additionally, your Coinsurance may be prorated to support the method of distribution and treatment. If a Network Provider charges an administration fee for Specialty Drugs, that amount would be separate from the cost of the medication. Charges for drug administration are considered medical services which are subject to the Copayment, Coinsurance and percentage payable provisions as explained in the **Summary of Benefits**.

The Specialty Pharmacy provides dedicated patient care coordinators to help you manage your condition and provides toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications. You or your doctor can order your Specialty Drug direct from the Specialty Pharmacy by simply calling (800) 659-4112. You will be assigned a patient care coordinator who will work with you and your Physician to obtain prior authorization and to coordinate the shipping of your medication directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your prescription.

Please note that Specialty Drugs may also be obtained from an Out-of-Network Specialty Pharmacy that agrees to accept the same payment terms as a contracted In-Network Specialty Pharmacy.

The following are not Covered Services under this Contract:

- Prescription Drug products for any amount dispensed which exceed the FDA clinically recommended dosing schedule;
- Prescription Drugs received through an Internet pharmacy Provider or mail order Provider except for PartnersRx designated mail order Provider;
- Non-Legend Vitamins;
- Smoking cessation products;
- Over-the-counter items;
- Cosmetic Drugs;
- Appetite Suppressants;
- Weight Loss Products;
- Diet supplements;
- Syringes (for other than insulin) except when in coordination with an approved injectable;
- Non-contraceptive injectables (except with pre-certification);
- The administration or injection of any Prescription Drug or any drugs or medicines;
- Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued;
- Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order;
- Prescription Drugs for which there is no charge;
- Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use;
- Prescription Drugs for use as an Inpatient or Outpatient in a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients;
- Charges for delivery of any Prescription Drugs;
- Drugs and medicines which do not require a prescription order and which are not Prescription Drugs;
- Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs;
- Prescription Drugs which are not Medically Necessary or which PartnersRx determines are not consistent with the diagnosis;
- Prescription Drugs which PartnersRx determines are not provided in accordance with accepted professional medical standards in the United States;
- Any services or supplies which are not specifically listed as covered under this Prescription Drug program;

- Prescription Drugs which are Experimental or Investigational in nature as explained in the "Limitations and Exclusions" section;
- Prescription medicine for nail fungus except for immunocompromised or diabetic patients.

Limitations and Exclusions

Pre-existing Conditions

Until coverage for a Member age 19 and over enrolled under this Contract (or any prior Creditable Coverage) has been in force for twelve consecutive months (except for Maternity Care), benefits for services to be paid by this program shall not be available for any illness, Injury or other condition for which:

- Medical advice, diagnosis, care, or treatment was recommended or received within the previous six months preceding the Effective Date of coverage of an individual Member.
- The Effective Date of coverage is subject to any length-of-service provision your employer requires; however, you will receive credit toward your pre-existing condition waiting period for any Employee length-of-service requirement which you must serve.

Unsatisfied Waiting Period Requirements

Any remaining portion of pre-existing waiting-period requirements not satisfied under prior Creditable Coverage must be fulfilled. Pre-existing condition waiting periods do not apply to Members under age 19.

What's Not Covered

Your coverage does not provide benefits for:

- **Allergy Services –** Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- **Acupuncture –** Acupuncture and acupuncture therapy.
- **Beautification Procedures –** Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by BCBSGA, is not covered.
    - This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
    - The following criteria must be met to qualify for breast reduction surgery: the affected area must be more than 250 grams over the normative average. Breast reduction surgery must meet certain criteria for coverage including a tissue removal minimum.
    - This exclusion does not apply to Breast Reconstructive Surgery. Please see the "Benefits" section of this Certificate Booklet.
- **Before Coverage Begins** – Services rendered or supplies provided before coverage begins, i.e., before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.
- **Behavioral Disorders** – Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or education testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to

services for conditions related to autistic disease of childhood (except to the same extent that the Contract provides for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.

- **Biomicroscopy** – Biomicroscopy, field charting or aniseikonic investigation.
- **Care, Supplies, or Equipment** – Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.
- **Complications** – Complications of non-covered procedures are not covered.
- **Counseling** – Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
- **Court-Order Services –** Court-ordered services, or those required by court order as a condition of parole or probation.
- **Covered Services –** Any item, service, supply or care not specifically listed as a Covered Services in this Certificate Booklet.
- **Crime –** Injuries received while committing a crime.
- **Daily Room Charges –** Daily room charges while the Contract is paying for an Intensive Care, cardiac care, or other special care unit.
- **Dental Care –** Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this SPD Booklet.
- **Drugs –** Any drug or other item which does not require a prescription.
- **Durable Medical Equipment –** The following items related to Durable Medical Equipment are specifically *excluded:*
    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Arch supports and orthopedic or corrective shoes;
    - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
    - Sterile water;
    - Deluxe equipment or premium services, such as motor driven chairs or beds, when standard equipment is adequate.
    - Rental or purchase of equipment if you are in a facility which provides such equipment;
    - Electric stair chairs or elevator chairs;
    - Physical fitness, exercise, or ultraviolet/tanning equipment;
    - Residential structural modification to facilitate the use of equipment;
    - Other items of equipment which BCBSGA feels do not meet the listed criteria.
- **Employer-Run Care –** Care given by a medical department or clinic run by your employer.

- **Experimental or Investigational –** Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in BCBSGA's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational services is not made eligible for coverage by the fact that other treatment is considered by a Participant's Physician to be ineffective or not as effective as the service or that the services is prescribed as the most likely to prolong life.
- **Failure to Keep a Scheduled Visit –** Charges for failure to keep a scheduled visit or for completion of claims forms; for Physician or Hospital's stand-by services, for holiday or overtime rates.
- **Foot Care –** Care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
- **Free Services –** Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
- **Government Programs –** Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- **Hair –** Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
- **Hearing Services –** Hearing aids, hearing devices and related or routine examinations and services.
- **Homes –** Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- **Hypnotherapy**
- **Ineligible Hospital –** Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
- **Ineligible Provider –** Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
- **Infertility –** Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or a combination thereof.
- **Injury or Illness –** Care, supplies, or equipment not Medically Necessary, as determined by BCBSGA, for the treatment of an Injury or illness.
- **Inpatient Mental Health –** Inpatient Hospital care for mental health conditions when the stay is:
  - Determined to be court-ordered, custodial, or solely for the purpose of environmental control;
  - Rendered in a home, halfway house, school, or domiciliary institution;
  - Associated with the diagnosis (es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related marital, social, cultural or work situation.
- **Inpatient Rehabilitation** – Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
  - The treatment is for maintenance therapy; or
  - The Participant has no restorative potential; or
  - The treatment is for congenital learning or neurological disability/disorder; or
  - The treatment is for communication training, educational training or vocational training.
- **Maternity Care** – Maternity benefits are not provided for Dependent children.
- **Maximum Allowed Amount** – Expenses in excess of the Maximum Allowed Amount as determined by BCBSGA.

- **Medical Reports** – Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- **Medicare** – Services paid under Medicare or which would have been paid if the Participant had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Participant has enrolled in Medicare Part B.
- **Miscellaneous Care** – Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.
- **Non-Physician Care** – Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care Providers as listed in this Certificate Booklet.
- **Not Medically Required** – Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
- **Obesity** – Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e.g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons. Jejunal bypasses and wiring of the jaw).
- **Orthoptics** – Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
- **Outpatient Therapy or Rehabilitation** – Services for outpatient therapy or rehabilitation other than those specifically listed in this Certificate Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetics therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide.
- **Personal Comfort Items** – Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
- **Private Room** – Private room, except as specified as Covered Services.
- **Provider (Close Relative)** – Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
- **Routine Physical Examinations** – Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Certificate Booklet.

- **Safe Surrounding** – Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
- **Sclerotherapy** – Sclerotherapy of extremity veins.
- **Self-Help** – Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
- **Sexual Modification/Dysfunction Treatments** – Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).
- **Shoes** – Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
- **Skilled Nursing Facility** – Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
- **Telehealth** – Telehealth consultations will not be reimbursable for the use of audio-only telephone, facsimile machine or electronic mail.
- **Thermograms** – Thermograms and thermography.
- **Transplants** – The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
    - Transportation, travel or lodging expenses for non-donor family members;
    - Donation related services or supplies associated with organ acquisition and procurement;
    - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
    - Any transplant not specifically listed as covered.
- **Transportation** – Transportation provided by other than a state licensed Professional Ambulance Service, and ambulance services other than in a Medical Emergency. Ambulance transportation from the Hospital to the home is not covered.
- **Treatment (Outside the U.S.)** – Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.
- **Vision** – Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Services or devices to correct vision or for advice on such service.
- **Vision (Surgical Correction)** – Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- **Waived Fees** – Any portion of a Provider's fee or charge which is ordinarily due from a Participant but which has been waived. If a Provider routinely waives (does not require the Participant to pay) a Deductible or Out-of-Pocket amount, BCBSGA will calculate the actual Provider fee or charge by reducing the fee or charge by the amount waived.
- **War** – Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
- **Workers' Compensation** – Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. *Exception:* Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if elected by the Group and additional Premium is paid.

Coordination of Benefits (COB)

If you, your spouse, or your Dependents have duplicate coverage under another BCBSGA program, any other group medical expense coverage, or any local, state or governmental program (except school accident insurance coverage and Medicaid), then benefits payable under this Contract will be coordinated with the benefits payable under the other program. BCBSGA's liability in coordinating will not be more than 100% of the Allowable Expense or the contracted amount.

Allowable Expense means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the programs covering the person for whom the claim is made. The claim determination period is the calendar year.

Order of Benefit Determination

When you have duplicate coverage, claims will be paid as follows:

- <u>Automobile Insurance</u>
  Medical benefits available through automobile insurance coverage will be determined before that of any other program if the automobile coverage has either no order of benefit determination rules or it has rules which differ from those permitted under applicable Georgia Insurance Regulations.
- <u>Non-Dependent/Dependent</u>
  The benefits of the program which covers the person as an Employee (other than as a Dependent) are determined before those of the program which covers the person as a Dependent.
- <u>Dependent Child/Parents Not Separated or Divorced</u>
  Except as stated below, when this program and another program cover the same child as a Dependent of different persons, called "parents":
  - The benefits of the program of the parent whose birthday falls earlier in a year are determined before those of the program of the parent whose birthday falls later in that year.
  - If both parents have the same birthday, the benefits of the program which covered the parent longer are determined before those of the program which covered the other parent for a shorter period of time.

However, if the other program does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the programs do not agree on the order of benefits, the rule in the other program will determine the order of benefits.

- <u>Dependent Child/Parents Separated or Divorced</u>
  If two or more programs cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the program of the parent with custody of the child;
  - Then the program of the spouse of the parent with custody of the child; and
  - Finally, the program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. This paragraph does not apply with respect to any claim determination period or program year during which any benefits are actually paid or provided before the company has that actual knowledge.

- Joint Custody
  If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the programs covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced."
- Active/Inactive Employee
  The benefits of a program that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a program that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other program does not have this rule, and if, as a result, the programs do not agree on the order of benefits, this rule is ignored.
- Longer/Shorter Length of Coverage
  If none of the above rules determine the order of benefits, the benefits of the program which covered an Employee or Member longer are determined before those of the program that covered that person for the shorter time.

Effect on the Benefits of this Program
This section applies when, in accordance with the Order of Benefit Determination Rules, this program is a secondary program to one or more other programs. In that event the benefits of this program may be reduced under this section. Such other program or programs are referred to as "the other programs" below.

Reduction in this program's benefits
The benefits of this program will be reduced when the sum of:
- The benefits that would be payable for the Allowable Expense under this program in the absence of this provision; and
- The benefits that would be payable for the Allowable Expenses under the other programs, in the absence of provisions with a purpose like that of this provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the benefits of this program will be reduced so that they and the benefits payable under the other programs do not total more than those Allowable Expense.

When the benefits of this program are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this program.

Miscellaneous Rights
- Right to Receive and Release Necessary Information
  Certain facts are needed to apply these rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this program must give us any facts needed to pay the claim.
- Facility of Payment
  A payment made under another program may include an amount which should have been paid under this program. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this program. We will not have to pay that amount again.
- Right of Reimbursement
  If the amount of the payment made by us is more than it should have paid under this provision, we may recover the excess from one or more of:
  - The persons we have paid or for whom we have paid,
  - Insurance companies, or
  - Other organizations.

Right of Recovery

- If you or your Covered Dependents have a claim for damages or a right to reimbursement from a third party or parties for any condition, illness or Injury for which benefits are paid under this program, BCBSGA shall have a right of recovery. BCBSGA's right of recovery shall be limited to the amount of any benefits paid for covered medical expenses under this program, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. BCBSGA's right of recovery shall include compromise settlements. You or your attorney must inform Anthem of any legal action or settlement discussion, ten days prior to settlement or trial. BCBSGA will then notify you of the amount it seeks, and the amount of your legal expenses it will pay.
- Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such recovery activity.

  We have oversight responsibility for compliance with Provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

  We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

Claims and General Information

Member Rights and Responsibilities

Your rights as a Blue Cross and Blue Shield of Georgia Member

As a Member, you have the right to:

- Recommend changes to the Member's Right and Responsibilities policy.
- Receive information about the Plan, its services, its Providers, and about your Rights and Responsibilities as a Member.
- Choose your primary care Physician from BCBSGA's network directory listing In-Network Providers and change your PCP.
- Receive considerate and courteous service with respect for personal privacy and human dignity through the Plan in a timely manner.
- Expect the Plan to implement policies and procedures to ensure the confidentiality of all your personal health information.
- Participate in full discussion with your Provider concerning the diagnosis, appropriate or Medically Necessary treatment options, and the prognosis of your conditions, regardless of whether or not the information represents a covered treatment or benefit.
- Receive and be informed about where, when, and how to obtain all benefits to which you are entitled under your Contract including access to routine services, as well as after-hours and emergency services.
- Be informed of your Premiums, Deductibles, Coinsurance and any maximum limits on Out-of-Pocket expenses for items and services (both In and Out-of-Network).
- Receive Plan rules regarding Deductibles and pre-certification including, but not limited to, pre-certification, concurrent review, post service review, or post payment review that could result in your being denied coverage of a specific service.
- Participate with Providers in the decision-making process concerning your health care.
- Refuse treatment and be informed by your Physician of the medical consequences.
- Receive specific information, upon your request, from In-Network Providers including, but not limited to, accreditation status, accessibility of translation or interpretation services, and credentials of Providers of direct patient care (limited to contracted Providers). BCBSGA encourages In-Network Providers to disclose such information upon Member request.
- Receive, upon request, a summary of how Physicians, Hospitals and other Providers are compensated using a variety of methodologies, including fee-for-service, per diem, discounted charges and global reimbursement.
- Express your opinions, concerns, or complaints about the Plan and the care provided by In-Network Providers in a constructive manner to the appropriate people within the Plan and be given the right to register your complaints and to appeal Plan decisions.
- Receive, upon request, a summary of the number, nature and outcome of all formally filed grievances filed with the Plan in the previous three years.
- Receive timely access to medical records and health information maintained by the Plan in accordance with applicable federal and state laws.

Your Responsibilities as a Blue Cross and Blue Shield of Georgia Member

As a Member, you have the responsibility to:

- Maintain your health and participate in the decisions concerning treatment.
- Ask questions and make certain that you understand the explanations and instructions you are given by your Physician, and comply with those conditions.

- Identify yourself as a Member when scheduling appointments or seeing specialty care and pay any applicable Coinsurance or Out-of-Pocket expenses in a timely manner.
- Keep scheduled appointments or give adequate notice of delay or cancellation.
- Furnish information regarding other health insurance coverage.
- Treat all In-Network Physicians and personnel respectfully and courteously as partners in good health care.
- Permit BCBSGA to review your medical records as part of quality management initiatives in order to comply with regulatory bodies.
- Provide, to the extent possible, information that the Plan and its Providers need in order to care for you.
- Follow the plans and instructions for care that you have agreed on with your Physician.

How to File Claims
Under normal conditions, BCBSGA should receive the proper claim form within 90 days after the service was provided. This section of your booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for you.

Each person enrolled through the Group's Contract receives an Identification Card. Remember, in order to receive full benefits, you must receive treatment from an In-Network Provider. When admitted to a BCBSGA In-Network Hospital, present your Identification Card. Upon discharge, you will be billed only for those charges not covered by your Group program. If you are admitted to an Out-of-Network Hospital that does not have an indemnity network agreement with BCBSGA, inform the admitting personnel of your BCBSGA coverage. The Hospital will bill BCBSGA directly for Covered Services.

When you receive Covered Services from an In-Network Physician or other In-Network licensed health care Provider, ask him or her to complete a Physician's Service Report form. Payment for Covered Services will be made directly to the Provider.

For health care expenses other than those billed by an In-Network Provider, use the Member Health Expense Report to report your expenses. You may obtain these from your employer or BCBSGA. Claims should include your name, Contract and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with BCBSGA. Be sure to keep a photocopy of all forms and bills for your records. The address is on the claim form.

For health care expenses other than those billed by a Preferred Provider, use the Member Health Expense Report to report your expenses. You may obtain these from your employer or BCBSGA. Claims should include your name, Contract and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with BCBSGA. Be sure to keep a photocopy of all forms and bills for your records. The address is on the claim form.

Save all bills and statements related to your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies. If you use a network pharmacy, the pharmacy will file the claim for you. If you do not use a network pharmacy, you must file the claim Prescription Drug receipts must show the prescription number and name of the drug, date of purchase, quantity, charge and the prescribing Physician's name.

Balance Billing
In-Network and Non-Preferred Providers are prohibited from balance billing. In-Network and Non-Preferred Providers have signed an agreement with BCBSGA, to accent its determination of the Maximum Allowed Amount for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of the Maximum Allowed Amount except what is due under the Contract, e.g., Copayments, Deductibles or Coinsurance.

Processing Your Claim

You are responsible for submitting your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain you have your Identification Card with you. Be sure the Hospital or Physician's office personnel copy your name, Group and Member ID numbers accurately when completing forms relating to your coverage.

If you are Hospitalized outside Georgia, the claim for Hospital services is usually handled in the same manner as within the state and the Hospital files the claim through its local Blue Cross and Blue Shield office. It may, however, be necessary for you to pay the Physician for his services and then submit an itemized statement to the BCBSGA office when you return home.

Timeliness of Filing

To receive benefits, a properly completed claim form with any necessary reports and records must be filed within one year of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified within 15 working days of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, BCBSGA has 15 working days to complete claims processing. BCBSGA shall pay interest at the rate of 18% per year to you or the assigned Provider if it does not meet these requirements.

Necessary Information

In order to process your claim, BCBSGA may need information from the Provider of the service. As a Member, you agree to authorize the Physician, Hospital, or other Provider to release necessary information.

BCBSGA will consider such information confidential. However, BCBSGA has the right to use this information to defend or explain a denied claim.

Unauthorized Use of Identification Card

If you permit a BCBSGA Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Questions About Coverage or Claims

If you have questions about your coverage, contact your Plan Administrator or BCBSGA's Customer Service Department. Be sure to always give your Member ID number. If you wish to get a full copy of the Utilization Review program procedures, contact the Customer Service Department.

Write

Customer Service Department
Paragon Benefits, Inc.
PO Box 12288
Columbus, GA 31917

When asking about a claim, give the following information:

- Member ID number;
- Patient name; Subscriber name and address;
- Date of service; type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a BCBSGA In-Network Provider, call them directly or call BCBSGA.

Right to Appeal

For all claims submitted by you or on your behalf, you will receive a notice (Explanation of Benefits) showing the amount charged; the amount paid by the program; and, if payment is partially or wholly denied, the reason.

If your claim is denied, you can appeal as outlined below. Any legal action must be brought within three years after the date the services or supplies were provided.

We Want You to be Satisfied

BCBSGA hopes that you will always be satisfied with the level of service provided to you and your family. BCBSGA realizes, however, that there may be times when problems arise and miscommunications occur which lead to feelings of dissatisfaction.

Complaints about BCBSGA Service

As a BlueChoice POS Member, you have a right to express dissatisfaction and expect unbiased resolution of issues. The following represents the process established to ensure that BCBSGA gives its fullest attention to your concerns. Please utilize it to tell BCBHSGA when you are displeased with any aspect of services rendered.

- Call the Customer Service Department. The phone number is on your ID Card. Tell the representative your problem and he or she will work to resolve it for you as quickly as possible.
- If you are not satisfied with the answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
- If, depending on the nature of your complaint, you remain dissatisfied after receiving BCBSGA's response, you will be offered the right to appeal the decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will hopefully bring the matter to a satisfactory conclusion for you.

Summary of Grievances

A summary of the number, nature and outcome results of grievances filed in the previous three years is available for your inspection. You may obtain a copy of any such summary at a reasonable cost from BCBSGA.

Complaints about Provider Service

If your complaint involves care received from a Provider, please call the Customer Service number. Your complaint will be resolved in a timely manner.

Terms of Your Coverage

BCBSGA provides the benefits described in this booklet only for eligible Members. The health care services are subject to the limitations, exclusions, Copayments, Deductible, and Coinsurance requirements specified in this booklet. Any Group BCBSGA Contract or Certificate which you received previously will be replaced by this Contract.

Benefit payment for Covered Services or supplies will be made directly to In-Network Providers. A Member may assign benefits to a Provider who is not an In-Network Provider, but it is not required. If a Member does not assign benefits to an Out-of-Network Provider, any benefit payment will be sent to the Member.

BCBSGA does not supply you with a Hospital or Physician. In addition, BCBSGA is not responsible for any Injuries or damages you may suffer due to actions of any Hospital, Physician or other person.

In order to process your claims, BCBSGA may request additional information about the medical treatment you received and/or other group health insurance you may have. This information will be treated confidentially.

An oral explanation of your benefits by a BCBSGA Employee is not legally binding.

Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying BCBSGA of your new address.

General Information
Fraudulent statements on Subscriber application forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Subscriber's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Both parties to this Contract (the employer and BCBSGA) are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire, etc.

BCBSGA will adhere to the employer's instructions and allow the employer to meet all of the employer's responsibilities under applicable state and federal law. It is the employer's responsibility to adhere to all applicable state and federal laws and BCBSGA does not assume any responsibility for compliance.

Small Group Rating
A Member covered under a small group Contract (from 2 to 50 Employees) is entitled to receive upon request certain rating information which documents the benefit design, demographic factors and Group experience factors since the pool rate utilized in the small Group's previous rating period. BCBSGA will respond to such request within ten (10) business days of the request for information.

Changes in Coverage
Your employer and BCBSGA may mutually agree to change the benefits described in this booklet. Fees charged for benefits described in this booklet may be changed:
- If the level of benefits changes; or
- If the ratio of benefits to fees exceeds an established level.

Acts Beyond Reasonable Control (Force Majeure)
Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

Licensed Controlled Affiliate
The Member hereby expressly acknowledges his/her understanding that this policy constitutes a Contract solely between the Member Group and BCBSGA, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSGA to use the Blue Cross and Blue Shield Service Marks in the state of Georgia, and that BCBSGA is not contracting as the agent of the Association. The Member Group further acknowledges and agrees that it has not entered into this policy based upon representation by any person other than BCBSGA and that no person, entity, or organization

other than BCBSGA shall be held accountable or liable to the Member for any of BCBSGA's obligation to the Member created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSGA other than those obligations created under other provisions of this agreement.

BlueCard POS

When you obtain health care services through BlueCard outside the geographic area BCBSGA serves, the amount you pay for Covered Services is usually calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to BCBSGA.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specific group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects **average** savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, BCBSGA would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

Accessing Care via the BlueCard POS Network

When you are out of state and need service, simply dial 1-800-810-2583. After you provide your ID number, alpha prefix and zip code in which you are seeking service, you will be given the name of at least three POS Providers in the area. You can decide which one to visit. In case of an emergency, you should seek immediate care from the closest health care Provider.

If you have to be admitted to a Hospital when you are out of state, remember you are responsible for receiving pre-certification/prior authorization from you Blue Cross and Blue Shield plan. If the required authorizations are not preformed and penalties are applied to the claim, you will be liable for the penalty amounts.

Care Received Outside the United States

You will receive Contract benefits for care and treatment received outside the United States. Contract provisions will apply. Any care received must be a Covered Service. Please pay the Provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. All services will be subject to appropriateness of care. BCBSGA will reimburse you directly. Payment will be based on the Maximum Allowed Amount. Assignments of benefits to foreign Providers or facilities cannot be honored.

Medicare
Any benefits covered under both this Certificate Booklet and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate Booklet provisions and federal law.

Except when federal law requires BCBSGA to be the primary payor, the benefits under this Certificate Booklet for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members, to the extent BCBSGA has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, BCBSGA will calculate benefits as if they had enrolled. For Medicare Part D. BCBSGA will calculate benefits upon receipt of the Member's Explanation of Medicare Benefits (EOMB) or Part D payment data obtained from an authorized Prescription Benefit Manager (PBM).

Governmental Health Care Programs
If you are enrolled in a Group with fewer than 20 Employees, your benefits will be reduced if you are eligible for coverage (even if you did not enroll) under any federal, state (except Medicaid) or local government health care program.

Under federal law, for Groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's health plan and receive Group benefits as primary coverage. Also, spouses (regardless of age) of active Employees can remain on the Group's health plan and receive Group benefits as primary coverage.

When Your Coverage Terminates

A. Termination of Coverage (Group)

BCBSGA may cancel this Contract in the event of any of the following:

- The Group fails to pay Premiums in accordance with the terms of this Contract.
- The Group performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.
- The Group has fallen below our minimum employer contribution or Group participation rules. We will submit a written notice to the Group and provide the Group 60 days to comply with these rules.
- We terminate, cancel or non-renew all coverage under a particular policy form, provided that:
    - We provide at least 180 days notice of the termination of the policy form to all Members;
    - We offer the Group all other small Group (employer) or large Group (employer) policies, depending on the size of the Group, currently being offered or renewed by us for which you are otherwise eligible; and
    - We act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

B. Termination of Coverage (Individual)

Group program membership for you and your enrolled family members may be continued as long as you are employed by the Group and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirements, if the Group Contract ceases, or if you fail to make any required contribution toward the cost of your coverage. In any case, your coverage would end at the expiration of the period covered by your last contribution. If your coverage terminates because of disability, your insurance may be continued until the end of a period of six months following the date the disability began. If your employment terminates because of a documented leave of absence approved by the Participating Employer, your insurance may be continued until the end of the policy month following the second policy month in which the leave of absence commenced.

Coverage of an enrolled child ceases automatically at the end of the month in which the child attains age 26. Coverage of a handicapped child over age 26 ceases if the child is found to be no longer totally or permanently disabled. Coverage of the spouse of a Member terminates automatically as of the end of the month in which there is a divorce or death.

Should you or any family members be receiving covered care in the Hospital at the time your membership terminates for reasons other than your employer's cancellation of this Contract, or failure to pay the required subscription charges, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

C. Continuation of Coverage (Georgia Law)

Any Employee insured in Georgia under a company welfare benefit plan whose employment is terminated other than for cause, may be entitled to certain continuation benefits. If you have been continuously enrolled for at least six months under this Contract, or this and its immediately preceding health insurance contract, you may elect to continue Group health coverage for yourself and your enrolled family members for the rest of the month of termination and three additional months by paying the appropriate Premium.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation, independently.

<u>Cost</u>

These continuation benefits are available without proof of insurability at the same Premium rate charged for similarly insured Employees. To elect this benefit you must notify the Group's Plan Administrator within 30 days of the date your

coverage would otherwise cease that you wish to continue your coverage and you must pay the required monthly Premiums in advance.

This continuation benefit is not available if:

- Your employment is terminated for cause; or
- Your health plan enrollment was terminated for your failure to pay a Premium or Premium contribution; or
- Your health plan enrollment is terminated and replaced without interruption by another Group Contract; or
- Health insurance is terminated for the entire class of Employees to which you belong; or
- The Group terminates health insurance for all Employees.

Termination of Benefits

Continuation coverage terminates if you do not pay the required Premium on time or you enroll for other Group insurance or Medicare.

Conversion

Conversion rights during the continuation period are the same as for insured Employees. If the Group terminates its health insurance Contract during an Employee's continuation period, the Plan Administrator must notify continuing Employees that conversion rights must be exercised within 31 days.

D. Continuation of Coverage (Federal Law – COBRA)

If your coverage ends under the plan, you may be entitled to elect continuation coverage in accordance with federal law. If your employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct, instead of the three months continuation benefit described above, you may elect from 18-36 months of continuation benefits, regardless of whether the Group is insured or self-funded.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your Group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and Group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Employee during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Employees:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction in Hours Worked	18 Months
<u>For Spouses/Dependents:</u> A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction in Hours Worked Covered Employee's Entitlement to Medicare Divorce or Legal Separation Death of a Covered Employee	18 months 36 months 36 months 36 months
<u>For Dependents:</u> Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

<u>Second qualifying event</u>
If your family has another qualifying event (such as a legal separation, divorce, etc.) during their initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), your spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your spouse or Dependent children to lose coverage under the plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employee who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.

Continuation of Coverage (Federal Law – USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Contract, and if he or she becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under this Contract. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Member and his or her Dependents can elect to continue coverage under this Contract for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Member returns to work, if the Member meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Member did not elect COBRA continuation. These requirements are (i) the Member gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Member must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Member must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). You may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Member upon reemployment, as well as to any Dependent who has become covered under this Contract by reason of the Member's reinstatement of coverage.

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay Out-of-Pocket.

E. When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other Group health plan after electing COBRA. If the other Group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA;
- The Group terminates all of its Group welfare benefit plans.

F. Continuation of Coverage (Age 60 and Over)

An Employee (and eligible Dependents), insured in Georgia under a company welfare benefit plan, who has exhausted the continuation benefits listed above, is eligible for additional continuation rights if that Employee was age 60 or older and covered for continuation benefits under the regular continuation provision.

There are certain requirements, which must be met:

- You must have been covered under a Group plan which covers 20 or more Employees; and
- You must have been continuously enrolled for at least six months under this Contract.

This continuation benefit is not available if:

- Your employment is terminated voluntarily for other than health reasons;
- The health plan enrollment was terminated because you failed to pay a Premium or Premium contribution;
- The health plan enrollment is terminated and replaced without interruption by another Group Contract;
- Health insurance is terminated for the entire class of Employees to which you belong;
- The Group terminated health insurance for all Employees;
- Your employment was terminated due to reasons which would cause a forfeiture of unemployment compensation (Chapter 8 of Title 34 “Employment Security Law”).

The following eligibility requirements apply:

- You must have been 60 years of age or older on the date coverage began under the continuation provision;
- Your Dependents are eligible for coverage if you meet the above requirements.
- Your spouse and any Covered Dependent children whose coverage would otherwise terminate because of divorce, legal separation, or your death may continue if the surviving spouse is 60 years of age or older at the time of divorce, legal separation or death.

The monthly charge (Premium) for this continuation coverage will not be greater than 120% of the amount you would be charged as a normal Group Member. You must pay the first Premium for this continuation of coverage under this provision on the regular due date following the expiration of the period of coverage provided under COBRA or state continuation.

Your continuation rights terminate on the earliest of the following:

- The date You fail to pay any required Premium when due;
- The date the Group Contract is terminated; (if the Group Contract is replaced, coverage will continue under the new Group plan.);
- The date You become insured under any other Group health plan;
- The date You or your divorced or surviving spouse becomes eligible for Medicare.

G. Extension of Benefits in Case of Total Disability

If the Group Contract is terminated for non-payment of subscription charges, or if the Group terminates the Contract for any reason, or if the Contract is terminated by us (with 60 days written notice), then in such event the coverage of a totally disabled Subscriber will be as follows:

- Contract benefits for the care and treatment of the specific illness, disease or condition that caused the total disability will be extended up to twelve (12) months from the date of termination of the Group Contract.

NOTE: We consider total disability a condition resulting from disease or Injury when:

- The Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- The Member’s Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

H. Special Requirements for COBRA and Conversion Rights

- COBRA is the first available option for continuing coverage.
- Any COBRA benefits must be exhausted for the entire COBRA eligibility period before conversion coverage will be provided.
- No conversion rights are available if a Member is enrolled or eligible for other Group coverage.

I. Extended Benefits

If a Member's coverage ends and he or she is totally disabled and, under a Physician's care BCBSGA extends major medical benefits for that Member under this Contract as explained below. This is done at no cost to the Member.

BCBSGA only extends benefits for Covered Services due to the disabling condition. The Covered Services must be incurred before the extension ends. What BCBSGA pays is based on all the terms of this Contract.

BCBSGA does not pay for charges due to other conditions. BCBSGA does not pay for charges incurred by other Covered Dependents.

The extension ends on the earliest of: (a) the date the total disability ends or (b) one year from the date the Member's coverage under this Contract ends. It also ends if the Member has reached the payment limit for his or her disabling condition.

NOTE: BCBSGA considers total disability a condition resulting from disease or Injury where:

- The Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- The Member's Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

J. Enhanced Conversion Rights

You and/or your Dependents may be a "qualifying eligible individual" for an enhanced conversion product if:

- Your most recent coverage was under a Group plan or continuation coverage;
- Coverage under this Contract has been terminated for any reason other than fraud or failure to pay a required Premium;
- All continuation (COBRA) coverage has been exhausted;
- There is 18 months of prior Creditable Coverage immediately prior to termination;
- You are not eligible for, nor have declined, any of the following:
  - Any Group health policy (including continuation under COBRA or state continuation);
  - Medicare;
  - Medicaid or similar program;
- You are not covered under any other creditable health insurance coverage, including individual or student health coverage.

You must file a substantially completed application for such enhanced conversion coverage, and pay the first Premium, no later than 63 consecutive days after a qualifying event, or the date of notice of enhanced conversion rights, whichever is later.

If you do not qualify for enhanced conversion rights, you may qualify for standard conversion rights as set out below.

K. Conversion Rights

NOTE: This section applies after you have exhausted any applicable continuation rights. A Member must have been covered under this Group Contract for six consecutive months in order to be eligible for conversion benefits.

A direct pay, billed-at-home contract providing Hospital and surgical benefits may be obtained, without medical examination or other evidence of insurability by:

- You, when your employment is terminated (Group conversion contract only);
- Your surviving spouse, when your coverage is terminated due to your death;

- Your child/children no longer eligible under your coverage (Group conversion contract only); or
- Your spouse when coverage is lost due to termination of the marriage;

provided we are notified within 31 days after termination of insurance. Information as to the coverage available and Premium rates can be obtained from us.

Any divorced spouse or widow/widower may apply within 31 days for a direct pay coverage contract most nearly similar to this Contract or any contract providing lesser coverage than being offered by us. This new Contract will be issued without evidence of insurability and will become effective on payment of the charge for the new coverage.

Time you have earned toward waiting periods under this Contract would carry over to the new Contract.

Definitions

Accidental Injury
Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity, or other cause) for care which the Member receives. It does not include injuries for which benefits are provided under any Workers' Compensation, employer's liability or similar law.

Applicant
This corporation, partnership, sole proprietorship, other organization or Group which applied for this Contract.

Application for Enrollment
The original and any subsequent forms completed and signed by the Subscriber seeking coverage. Such Application may take the form of an electronic submission.

Benefit Period
One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Centers of Expertise (COE) Network
A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

The network of health care professionals that entered into Contracts with Blue Cross Blue Shield of Georgia, or one or more of its affiliates, to provide transplant or other designated specialty services.

Certificate
A short written statement which defines BCBSGA's legal obligation to the individual Members. It is part of this Certificate Booklet.

Chemical Dependency (Substance Abuse)
The total psycho-physical state of mind that involves feelings of satisfaction and a drive to periodic or continuous administration of the chemical (drug) to produce pleasure or avoid discomfort.

Chemical Dependency Treatment Facility
An institution established to care for and treat Chemical Dependency, on either an Inpatient or outpatient basis, under a prescribed treatment program. The institution must have diagnostic and therapeutic facilities for care and treatment provided by or under the supervision of a licensed Physician. The institution must be licensed, registered or approved by the appropriate authority of the State of Georgia or must be accredited by the Joint Commission on Accreditation of Hospitals.

Coinsurance
If a Member's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Limit.

Combined Limit
The maximum total of In-Network and Out-of-Network Benefits available for designated health services in the Summary of Benefits.

Complications of Pregnancy
Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly
A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Contract
This Certificate Booklet in conjunction with the Group Master Contract, the Group Master Contract Application, the BCBSGA Formulary, any amendment or rider, your Identification Card and your Application for Enrollment constitutes the entire Contract. If there is any conflict between either this Certificate Booklet or the Group Master Contract and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Certificate Booklet and the Group Master Contract, the Group Master Contract shall control.

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

Coordination of Benefits
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Cosmetic Surgery
Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent
Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Certificate Booklet, has enrolled in the program, and is subject to Premium requirements set forth in the Group Master Contract.

Covered Services
Those charges for Medically Necessary health care services and supplies that are (a) defined as Covered Services in the Member's Contract, (b) not excluded under such Contract, (c) not Experimental or Investigational and (d) provided in accordance with such Contract.

Creditable Coverage
Coverage under another health benefit program is medical expense coverage with no greater than a 90 day gap in coverage under any of the following: (a) Medicare or Medicaid; (b) an employer-based accident and sickness insurance or health benefit arrangement; (c) an individual accident and sickness insurance policy; (d) a spouse's benefits or coverage under Medicare or Medicaid or an employer-based health insurance benefit arrangement; (e) a conversion policy; or (f) similar coverage as defined in OCGA 33-30-15.

Custodial Care
Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirement of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which to not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of BCBSGA, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible
The portion of the bill you must pay before your medical expenses become reimbursable. It usually is applied on a calendar year basis.

Dependent
The spouse and all children until attaining age 26. Children include natural children, legally adopted children and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree. Foster children whom you expect to raise to adulthood and who live with you in a regular parent-child relationship are considered children. However, for the purposes of this Contract, a parent-child relationship does not exist between you and a foster child if one or both of the child's natural parents also live with you.

In addition, BCBSGA does not consider as a Dependent, welfare placement of a foster child, as long as, the welfare agency provides all or part of the child's support.

Mentally or physically handicapped children remain covered no matter what age. You must give BCBSGA evidence of your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from BCBSGA or your employer. This proof of incapacity may be required annually by BCBSGA. Such children are not eligible under this Contract if they are already 26 or older at the time coverage is effective.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury. Services rendered should be to treat or promote recovery of the specific functional deficits identified.

Durable Medical Equipment

Equipment, as determined by BCBSGA, which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

The date for which BCBSGA approves an individual application for coverage. For individuals who join this Group after the first enrollment period, the Effective Date is the date BCBSGA approves each future Member according to its normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Emergency Medical Services

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment to stabilize the patient.

The term **"stabilize"** means, with respect to an emergency medical condition:
To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee
A person who is engaged in active employment with the Group and is eligible for Group coverage with BCBSGA under the employment regulations of the Group.

Experimental or Investigational
Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikcus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
- The following standard reference compendia; the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
- It meets the Technology Assessment Criteria as determined by BCBSGA as outlined in the "Definitions" section of this Certificate Booklet.

Freestanding Ambulatory Facility
A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis – no patients stay overnight. The facility offers continuous service by both Physicians and Registered Nurses (R.N.s). It must be licensed by the appropriate state agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Group
The Subscriber's employer, which has entered the Group Master Contract with BCBSGA. The Group shall act only as an agent of Members who are Subscribers of the Group and their Covered Dependents.

Home Health Care
Care, by a state-licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency
A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate state agency.

Hospice
A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate state agency.

Hospice Care Program
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate state agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital
An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

Identification Card
The latest card given to you showing your Member and Group numbers, the type of coverage you have and the date coverage became effective.

Ineligible Charges
Charges for health care services that are not Covered Services because the services are not Medically Necessary or pre-admission certification was not obtained. Such charges are not eligible for payment.

Ineligible Hospital
A facility which does not meet the minimum requirements to become an In-Network Hospital. Services rendered to a Member by such a Hospital are not eligible for payment.

Ineligible Provider
A Provider which does not meet the minimum requirements to become an In-Network Provider or with which BCBSGA does not directly contract. Services rendered to a Member by such a Provider are not eligible for payment.

Infertile or Infertility
The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee
A person actively employed by the Group (or one of that person's Covered Dependents) on the original Effective Date of the Group Master Contract between BCBSGA and the Group or currently enrolled through the Group under a BCBSGA contract.

Injury
Bodily harm from a non-occupational accident.

In-Network Provider (Network Provider)
Sometimes referred to as Preferred Provider, a Hospital, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services and supplies that has a Point of Service (POS) Contract with BCBSGA to provide Covered Services to Members.

Inpatient
A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit
A special care unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Late Enrollees
Late Enrollees means Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Contract; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Contract, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to BCBSGA that coverage was declined because other coverage existed.

Maternity Care
Obstetrical care received both before and after delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Contract.

Maximum Allowed Amount
The Maximum Allowed Amount is the maximum amount of reimbursement BCBSGA will pay for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Plan.

MCSO – Medical Child Support Order
An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- Provides for child support payment related to health benefits with respect to the child of a Group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to a Group health plan.

Medical Facility
Any Hospital, Freestanding Ambulatory Facility, Chemical Dependence Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Certificate Booklet. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by BCBSGA.

Medical Necessity or Medically Necessary
BCBSGA reserves the right to determine whether a health care service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. BCBSGA considers a health care service Medically Necessary if it is:

- Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- Compatible with the standards of acceptable medical practice in the United States;
- Not provided solely for your convenience or the convenience of the Physician, health care Provider or Hospital;
- Not primarily Custodial Care; and
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

Member
The Subscriber and each Dependent, as defined in this booklet, while such person is covered by this Contract.

Mental Health Disorders
Includes (whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or Chemical Dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, Chemical Dependency disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

New Hire
A person who is not employed by the Group on the original Effective Date of the Group Master Contract.

Non-Covered Services
Services that are not benefits specifically provided under the Contract, are excluded by the Contract, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Non-Preferred Provider
A Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have a Point of Service (POS) Contract with BCBSGA but is contracted for our indemnity network.

Out-of-Network benefits apply when Covered Services are rendered by a Non-Preferred Provider.

Nurse Practitioner (NP)
An individual duly licensed by the State of Georgia to provide primary nursing and basic medical services.

Out-of-Network Provider
A Hospital, Freestanding Ambulatory Facility (surgical center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have a POS network Provider Contract with BCBSGA.

Out-of-Pocket Limit (May apply to In-Network or Out-of-Network – Refer to Summary of Benefits)
The maximum amount of a Member's Coinsurance payments during a given calendar year. Such amount includes Deductibles. Such amounts do not include charges for Non-Covered Services, or charges in excess of the Maximum Allowed Amount. When the Out-of-Pocket Limit is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services, exclusive of Copayments and other scheduled charges.

Periodic Health Assessment
A medical examination that provides for age-specific preventive services that improve the health and well-being of a patient being examined.

Physical Therapy
The care of disease or Injury by such methods as massage, hydrotherapy, heat or similar care.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Contract.

Physician Assistant (PA)
An individual duly licensed by the State of Georgia to provide basic medical services under the supervision of a licensed Physician.

Physician Assistant Anesthetist (PAA)
An individual duly licensed by the State of Georgia to provide anesthesia services under the supervision of a licensed Physician specializing in anesthesia.

Plan Administrator
The person named by your employer to manage the program and answer questions about program details.

Preferred Provider
Sometimes referred to as In-Network Provider, a Hospital, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services and supplies that has a Preferred Provider Organization (POS) Contract with BCBSGA to provide Covered Services to Members.

Premium
The amount that the Group or Member is required to pay us to continue coverage.

Prescription Drug
A drug which cannot be purchased except with a prescription from a Physician.

Professional Ambulance Service
A state-licensed emergency vehicle which carries via the public streets injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Provider
Any Physician, health care practitioner, pharmacy, supplier or facility, including, but not limited to, a Hospital, clinical laboratory, freestanding ambulatory surgery facility, Skilled Nursing Facility, long term acute care facility or Home Health Care Agency holding all licenses required by law in the State of Georgia to provide health care services.

QMCSO – Qualified Medical Child Support Order
A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

Respite Care
Care furnished during a period of time when the Member's family or usual caretaker cannot, or will not, attend to the Member's needs.

Semiprivate Room
A Hospital room which contains two or more beds.

Similar Drugs
Similar Drugs are those within a certain therapeutic class such as insomnia drugs, oral contraceptives, seizure drugs, etc.

Skilled Convalescent Care
Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility
An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate state agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by BCBSGA to meet the reasonable standards applied by any of the aforesaid authorities.

Specialty Drugs
High-cost injectable, infused, oral or inhaled medications that typically require close supervision and monitoring of their effect on the patient by a medical professional. Specialty Drugs often require special handling such as temperature-controlled packaging and overnight delivery and are often unavailable at retail pharmacies. Most Specialty Drugs require preauthorization.

Specialty Pharmacy
A pharmacy which dispenses biotech drugs for rare and chronic diseases via scheduled drug delivery either to the Member's home or to the Physician's office. These pharmacies also provide telephonic therapy management to ensure safety and compliance.

Subscriber
The individual who signed the Application for Enrollment and in whose name the Identification Card is issued.

Substance Abuse
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Rehabilitation
Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment plans.

Substance Abuse Residential Treatment Center
A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Substance Abuse Services within a General Hospital Facility
A general Hospital facility that provides services, on an Inpatient, 24-hour basis, for medical Detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

Technology Assessment Criteria
Five criteria all investigative procedures must meet in order to be Covered Services under this Contract.

- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology of health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternative.
- The technology must be beneficial in practice.

Telehealth Services
A health care service, other than a Telemedicine service, delivered by a licensed or certified health professional, acting within the scope of the healthcare professional's license or certification, who does not perform a Telemedicine Medical Service, that requires the use of advanced telecommunications technology, other than by telephone or facsimile including:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture; and
- Other technology that facilitates access to healthcare services or medical specialty expertise.

Telemedicine Medical Service
A health care medical service initiated by a Physician or provided by a health care professional, diagnosis, treatment or consultation by a Physician, or the transfer of medical data that requires the use of advance communications technology, other than by telephone or facsimile including;

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture; and
- Other technology that facilitates access to healthcare services or medical specialty expertise.

Neither a telephone conversation nor an electronic mail message between a healthcare practitioner and a patient is telemedicine.

Therapeutic/Clinically Equivalent
Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. “Clinically/Therapeutic equivalent” means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. Therapeutic/Clinically Equivalent determinations are based on industry standards and reviewed by such organizations as The Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services.

Urgent Care
An Urgent Care medical problem is an unexpected episode of illness or Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an emergency. Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. Benefits provided for Urgent Care Services are outlined in the **Summary of Benefits**.

Urgent Care Center
A facility, appropriately licensed and meeting BCBSGA standards for an Urgent Care Center, with a staff of Physicians and health care professionals that is organizationally separate from a Hospital and whose primary purpose is providing urgently needed medical procedures. Services are performed on an outpatient-basis and no patients stay overnight. A Physician’s office does not qualify as an Urgent Care Center.

Utilization Review
A function performed by AHH or by an organization or entity selected by AHH to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute Hospitalization, length of stay, outpatient care or diagnostic services are appropriate.

Statement of ERISA Rights

General Information About ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other Employees, ERISA imposes duties on the people responsible for the operation of your Employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Claims Disclosure Notice

This Certificate Booklet contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or BCBSGA. In addition to this information, if this *plan* is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in this Certificate Booklet.

Urgent Care. BCBSGA must notify you, within 72 hours after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If your request for benefits does not contain all the necessary information, BCBSGA must notify you within 24 hours after receiving it and tell you what information is missing. Any notice to you by BCBSGA will be orally by telephone or in writing by facsimile or other fast means. You have at least 48 hours to give BCBSGA the additional information needed to process your request for benefits. You may give BCBSGA the additional information needed orally by telephone or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after BCBSGA's receipt of the request for benefits or 48 hours after receipt of all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The notice will explain the reason for the denial and the plan provision upon which the decision is based. You have 180 days to appeal the decision. You may appeal the decision orally by telephone or in writing by facsimile or other fast means. Within 72 hours after BCBSGA receives your appeal, if your claim is still considered urgent under the circumstances at the time of the appeal, BCBSGA must notify you of the decision. BCBSGA will notify you orally by telephone or in writing by facsimile or other fast means. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-Service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). BCBSGA must notify you, within 15 days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If BCBSGA needs more than 15 days to determine your benefits, due to reasons beyond BCBSGA's control, BCBSGA must notify you within that 15-day period that more time is needed to determine your benefits. But, in any case, even with an extension, BCBSGA cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your claim, BCBSGA must notify you, within 5 days after receiving it and tell you what information is missing. You have 45 days to provide BCBSGA with the information needed to process your request for benefits. The time period during which BCBSGA is waiting for receipt of the necessary information is not counted toward the time frame in which BCBSGA must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the denial within the time frame noted above after BCBSGA has all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The written notice will explain the reason for the denial and the plan provisions upon which the decision was made. You have 180 days to appeal an adverse benefit determination. Your appeal must be in writing. Within 30 days after a pre-service appeal is received. BCBSGA must notify you of the decision. BCBSGA's notice of the decision will be in writing.

Concurrent Care Decisions. If, after approving a request for benefits in connection with your illness or Injury, BCBSGA decides to reduce or end the benefits that had been approved for you, in whole or in part:

- BCBSGA must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal the decision before the reduction in benefits or end of benefits occurs. In the notice to you, BCBSGA must explain the reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
- To keep the benefits you already have approved, you must successfully appeal the decision to reduce or end those benefits. You must make your appeal to BCBSGA at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal will be treated as if you were appealing a Non-Urgent Care denial of benefits (see "Urgent Care" above).

- If your appeal for benefits is received at least 24 hours prior to the occurrence of the reduction or ending of benefits, BCBSGA must notify you of the decision regarding your appeal within 72 hours of the receipt of your appeal. If you appeal of the decision to reduce or end your benefits is denied, in whole or in part, BCBSGA must explain the reason for the denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an Urgent Care denial of benefits (see "Urgent Care" above).

Non-Urgent Care Post-Service (reimbursement for cost of medical care). BCBSGA must notify you, within 30 days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. (In order to comply with Georgia law, BCBSGA will address claims for services already rendered within 15 business days or receipt.) If more than 30 days are needed to determine your benefits, due to reasons beyond BCBSGA's control, BCBSGA must notify you within that 30-day period that more time is needed to determine your benefits. But, in any case, even with an extension, BCBSGA cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for you claim, BCBSGA must notify you, within 30 days after receiving it and tell you what information is missing. You have 45 days to provide the information needed to process your claim. The time period during which BCBSGA is waiting for receipt of the necessary information is not counted toward the time frame in which BCBSGA must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above after BCBSGA has all the information needed to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the decision was made. You have 180 days to appeal the adverse benefit determination. Your appeal must be in writing. Within 60 days after receiving your appeal, BCBSGA must notify you of the decision. The notice to you of the decision will be in writing.

Note: You, your beneficiaries, or a duly authorized representative may appeal any denial of a claim for benefits with BCBSGA and request a review of the adverse benefit determination. In connection with such a request, documents pertinent to the administration of the plan may be reviewed free of charge; and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure. Medical information BCBSGA has regarding your case will be released to you or an attorney only by written authorization from your Provider and/or the Hospital.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of mental health and Substance Abuse benefits with medical/surgical benefits. In general, Group health plans offering mental health and Substance Abuse benefits cannot set benefits that are lower than benefits for medical and surgical benefits. The Plan may not impose Deductibles, Copayments/Coinsurance and out of pocket expenses on mental health and Substance Abuse benefits that are more restrictive than Deductibles, Copayments/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

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

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the **Summary of Benefits**.

If you would like more information on WHCRA benefits, call your Plan Administrator.

Greater Georgia Life Insurance Company

This booklet-Certificate is not a policy Contract or a part of the Group policy. It merely describes in general terms the benefits provided by the Group life insurance policy issued to Georgia Bankers Association Insurance Trust. The Policy is on file at the office of the Policyholder and may be inspected there.

Greater Georgia Life Insurance Company

GENERAL INFORMATION
Home Office: Atlanta, Georgia

Group Term Life Insurance
Your Certificate Schedule shows the specific benefits and amounts of coverage you have.

Definitions
"We", "our", and "us" refer to Greater Georgia Life Insurance Company. We may use "he", "his", or "him" to refer to an insured person, male or female.

An "insured person" means:
- You, and
- Your eligible Dependents for whom enrollment requirements have been met, and for whom all the Premiums have been paid.

"Active" means:
- For you, that you are actively at work at your normal place of employment;
- For a Dependent, that he is not confined in a Hospital and that he is able to carry on regular activities customary of a person in good health of the same age and sex.

"Employer" or "Participating Employer" means a Member of the Georgia Bankers Association (or certain affiliates of the Georgia Bankers Association), who has adopted this Plan of Insurance. Each Employer that adopts this Plan of Insurance selects a specific Benefit Schedule that applies to its respective eligible Employees. However, any provisions that are based on service with an Employer, such as eligibility provisions, limitations, etc., are based on service with all Employers who have adopted the Plan.

"Retired Employee" means for insurance purposes a former Active Full-Time Employee who has completed at least 10 years of service and is at least 55 years of age.

N/A means "not applicable".

Who Is An Eligible Employee
If you are an active full-time Employee working at least 30 hours per week you are eligible for insurance on the first day of the month following your Employer's length-of-service requirement.

Who Are Eligible Dependents
Your Dependents become eligible at the same time you become insured.

Eligible Dependents are:
- Your spouse, provided you are not legally separated.
- Your unmarried children who are
    - Age 14 days to 26 years

Children include:
- Your children
- Legally adopted children
- Foster children

The term “Dependent” does not include any person who:

- is eligible as an Employee;
- is an active Member of the armed forces of any country; or
- is permanently residing outside the United States and Canada

If both you and your spouse can be insured as Employees, only one of you may insure eligible children as Dependents.

When Insurance Begins
Your insurance and the insurance for each Dependent becomes effective on the Effective Date shown on your Summary of Benefits provided the person to be insured has applied for it and is “active” on that date. Otherwise, the person’s insurance will become effective on the date the person becomes “active”.

If you are required to pay all or part of the cost of insurance, evidence of insurability will be required if the application for the person to become insured is received more than 31 days after becoming eligible. When evidence is required, insurance will become effective on the first day of the month following approval.

Scheduled Reduction
On January 1 coincident with or next following the date the active Employee attains age 70, the amount of Life and AD&D insurance showing in your Summary of Benefits will be reduced to 30% of that amount. If the amount of coverage is great than $250,000, that amount will be reduced to $250,000 then 30% of that amount.

Refer to “Continuation After Retirement” for further reduction information.

When Increases or Decreases in Amounts of Insurance Are Effective
Increases in amounts of insurance are effective on the 1st day of the month on or next following the date of the change. An insured person must be active on the date any increase in insurance is to become effective. Otherwise, that person’s increase will become effective on the date he becomes active. Evidence of insurability may be required as outlined in the Group policy.

When evidence is required, the date the increase becomes effective for such person will be subject to our approval of the evidence.

Decreases in amounts of insurance occur on the first day of the month on or next following the date of the change. The Effective Date of a scheduled reduction upon attainment of a stated age is January 1 coincident with or next following the event.

When Insurance Terminates
Your insurance will terminate the end of the month following the earliest of:

- the date the Group policy ends;
- the date you end your employment or retire (unless the Group policy provides continuation of coverage for retired Employees and you are a qualified retiree);
- the date you cease to meet the definition of “insured person”;
- the date your employment classification is deleted from the Group policy or you cease to be eligible under any Employee classification;
- the date you stop making a contribution, if contributions are required;
- the date your employer’s business ceases to be eligible for any reason.

Your Dependent's insurance will terminate the end of the month following the date below which occurs first:

- the date you cease to be an insured person, unless insurance is continued temporarily as outlined in the section on "Continuance Due to Sick Leave or Leave of Absence" that follows;
- the date your Dependent ceases to meet the definition of "Dependent" or "insured person".

Continuance Because of Total Disability – Waiver of Premium

If you become totally disabled, you may be entitled to continue your Group term life insurance as provided in the Group Policy if you:

- are less than 60 years of age;
- are unable to engage in any business or perform any work for pay or profit; and
- furnish proof of your disability after you have been disabled at least nine months and not later than one year after your active employment was terminated.

After we acknowledge your disability, We will:

- continue your Term Life Insurance (does not include Supplemental Life Insurance, AD&D or Dependent Life);
- waive Premiums for your Term Life Insurance; and
- require periodic evidence of your continuing disability.

Insurance continued under this provision is subject to "Scheduled Reductions" and terminates upon attainment of age 70.

Continuance Due to Sick Leave or Leave of Absence

If Premiums are paid and the Group policy remains in force, Insurance may be continued for:

- up to three months if you are granted an authorized leave of absence; or
- up to three months if you are temporarily laid off; or
- up to three months if you are temporarily placed on a part time employment bases; or
- up to a maximum of twelve months if you are unable to work due to disability which results from illness or Accidental Injury.

Continuance After Retirement

As a qualified retiree, you may be eligible for Term Life Insurance continuation after retirement. A Retired Employee for insurance purposes is a former Active Full-Time Employee of the Employer who:

- has completed at least 10 years of service; and
- is at least 55 years of age.

The amount of Life Insurance will be the amount in effect on the day before the date of retirement. If the amount of coverage is greater than $250,000, that amount will be reduced to $250,000 upon retirement.

On January 1 coincident with or next following the dates shown below, (or January 1 of the year following retirement and each anniversary thereafter if retirement takes place prior to age 65), the amount of life insurance will be reduced according to the following table:

Age	Reduces to
65	80%
66	60%
67	40%
68 and over	30%

Accidental death and dismemberment benefits terminate on January 1 on or next following the date you retire.

Termination of Dependent insurance continued under this provision is concurrent with the termination of a Retired Employee's Insurance.

Check with your employer for more detailed information regarding retirement benefits and eligibility.

GROUP TERM LIFE BENEFITS
If an insured person dies while insured under the Group policy, we will pay the beneficiary the amount of Group term life insurance then in effect. We can require proof of eligibility for coverage before making claim payments; this information will be requested if needed. Benefits for suicide during the first two years may be limited.

Assignment of Benefits
You may not make a valid assignment of life insurance unless it is in writing and filed with and approved by us. To be valid, an assignment must be absolute and irrevocable. We assume no liability for its sufficiency.

Conversion Privilege
You or your Dependents (if insured) may apply, without evidence, for an individual policy of life insurance to replace all or part of term life insurance that ceases because;

- your employment has terminated;
- eligibility for term life insurance has ended;
- of your death.

If you have been insured for five continuous years or more, you or your Dependents (if insured) will also have this right if term life insurance ceases because of:

- termination of the Group policy;
- amendment of the policy as to terminate your class.

Schedule reductions in the amount of insurance when you reach a stated age are not convertible.

The individual policy may be a plan we offer for sale at the time it is applied for. It cannot be a preferred risk plan or a policy containing term insurance or disability insurance.

The individual policy will go into effect at the end of the 31 day conversion period.

Conversion Period
You or your Dependents (if insured) must make written application for the individual policy and pay the first Premium within 31 days after insurance under this policy ceases. If insurance is continued under any provision of the Group policy, application and Premium payment must be made within 31 days after the period of continuance ends.

If any insured person dies within the 31 day conversion period, we will pay the amount of insurance that he was entitled to convert. We will pay that amount whether or not an application has been made. But a claim cannot be made under both the Group policy and under the individual policy.

Amount Which May Be Converted

1. If insurance ends for a reason other than policy termination of amendment, the full amount may be converted.
2. If the Group policy terminates or is amended to terminate insurance, the amount convertible will be the amount terminated less the amount of any life insurance for which the insured person becomes eligible under any Group policy within 31 days after termination. The maximum is $2,000.
3. If the Group policy terminates within 31 days following your termination, the amount which may be converted will be determined by 2 rather than 1 above.

Beneficiary Designation

You are the beneficiary for all benefits payable except for benefits payable upon your death.

You name your beneficiary at the time you complete your enrollment form. Unless there is a legal restriction, you may change your beneficiary at any time by filing a written request with us or your employer. Subject to any payment or action taken prior to our receiving the change or notice of the change from your employer in our home office, the change will become effective as of the date of the request.

If there are two or more beneficiaries at your death and the share for each is not shown, we will pay them in equal shares.

If there is no legally appointed beneficiary living at the time of your death, your estate will be the beneficiary.

Accelerated Death Benefit

This Group Policy provides for an accelerated payment of a portion of your life insurance benefit amount if you are diagnosed with “terminal illness”. To be eligible for such an accelerated payment, your life insurance amount must be equal to or greater than $15,000.
If you are diagnosed with a “terminal illness”, you may request an accelerated payment of a portion of your life insurance benefits. The life insurance benefit amount will be determined as the date “Notice of Claim” is received by the Insurer. The maximum accelerated death benefit payable is limited to fifty percent (50%) of the life insurance amount, not to exceed $100,000 for all policies or Certificates issued by “us”.

To apply for this benefit:

- A written request must be made by you (“we” will provide proper forms and instructions upon request);
- Acceptable proof of your “terminal illness” must be provided. Proof will include, but is not limited to, a written Physician certification documenting the nature and extent of the condition(s) involved and stating that it will, in the medical judgment of the Physician, directly result in a life expectancy of 12 months or less. “We”, Greater Georgia Life, may at our expense, require an independent examination by a Physician of “our” choice; and
- A signed acknowledgment and agreement from any assignee or irrevocable beneficiary, if any, as to payment of the accelerated death benefit must be provided.

An accelerated death benefit will be paid only if you are living at the time of payment. The benefit will be paid in one lump sum and is subject to a $200 administrative fee. Upon your death, the beneficiary will receive the life insurance amount in effect as of the time of death, less the amount of any accelerated death benefit paid to the Employee. Only one accelerated death benefit will be paid to an Employee.

This benefit will not apply:

- to any intentionally self-inflicted Injury or suicide attempt for a period of two (2) years from your Effective Date of coverage;
- if diagnosis was made and disability began on or after insured's 60th birthday;
- if the Premium is due and unpaid beyond the 31 day grace period;
- if you are required by law to use this benefit to meet the claims of creditors, whether related to bankruptcy or otherwise;
- to any insurance amount of less than $15,000, unless a signed acknowledgment and agreement of assignee or irrevocable beneficiary is received;
- when all or a portion of your life insurance amount is assigned;
- if prognosis of your terminal illness was made prior to the Effective Date of your coverage.

This benefit may or may not be taxable. You are advised to seek the advice of a professional tax advisor in this matter.

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
(Refer to your Summary of Benefits to determine if applicable to you)

You are insured for loss of life, limbs, or sight as a result of accidental bodily Injury. Accidental bodily Injury means an Injury caused to the body by accident, directly and independently of any other cause. The loss must occur within 90 days after the accident.

The amount payable, known as the Principal Sum, is shown in the Summary of Benefits and is the maximum that we will pay for all your injuries, as outlined below, whenever they occur.

Loss Of	Amount Payable
Life	The Principal Sum
More than one Member	The Principal Sum
One Member	½ The Principal Sum

Loss is defined as:

- severance of the hand at or above the wrist;
- severance of the foot at or above the ankle joint;
- the permanent loss of the entire sight of an eye.

We will not pay for any loss caused by:

- disease or bodily or mental infirmity, or any kind of treatment for those conditions;
- suicide, attempted suicide or intentional, self-inflicted Injury;
- aeronautic operations as a pilot or crew member;
- war, declared or undeclared;
- Injury while you are in military service;
- committing, or attempting to commit, a felony or assault;
- being under the influence of alcohol; voluntarily taking any hallucinogen, narcotic, or drug unless prescribed for the Employee by a Physician; voluntarily inhaling gas or fumes or voluntarily taking poison.

Benefit Payments

Submitting a Claim
Your employer has the necessary forms and can assist in submitting life, disability, or other claim to us.

When Benefits Are Paid
We will pay benefits as soon as possible once we receive satisfactory proof of loss.

To Whom and How Benefits Are Paid
Benefits for the loss of life will be paid as set out in the beneficiary provision.
You may instruct us to make payment in one of these ways;
-in one single payment,
-in equal monthly installments over a fixed period of time,
-in any other method of payment to which we agree.

- If you die without choosing a method of payment, your beneficiary may choose the method of payment. If no method of payment is chosen, we will pay the amount in one single payment. Installments include guaranteed interest at a compound annual rate of 3.5%. We may pay additional interest from time to time.
- Interest will be added to the single payment only if we do not make the payment within 30 days after we receive proof of death. If payment is made more than 30 days after date of death, we will pay interest from the date of death to the date of payment, except that no interest will be paid if the amount is less than five dollars. Interest will not be less than 6% a year nor less than required by state law.

Benefits due at your death will be paid to the beneficiary as designated by you for your Group Term Life Insurance.

All other benefits will be paid to you.

Summary Plan Description

The purpose of this notice is to furnish you with certain information regarding our Employee health benefit plan as required by The Employee Retirement Income Security Act of 1974. If this notice fails to answer your questions regarding any aspect of this plan, please contact the Plan Administrator named below. This person will help you understand fully your rights and obligations under the plan.

- **Plan Name.**
  Group Benefits Plan for full-time Employees of the Participating Employers of the Georgia Bankers Association Insurance Trust, Inc.

- **Plan Sponsor.**
  Group Benefits Plan for full-time Employees of the Participating Employers of the Georgia Bankers Association Insurance Trust, Inc.

- **Plan Number.**
  58-2241094

- **Employer I.D. Number.**
  501

- **Type of Plan.**
  The Plan provides health coverage.

- **Plan Year Ends.**
  December 31st

- **Plan Administrator and Named Fiduciary.**
  Georgia Bankers Association Insurance Trust, Inc.
  50 Hurt Plaza, Suite 1050
  Atlanta, GA 30303
  (404) 522-1501

- **Agent for Service of Legal Process.**
  Georgia Bankers Association Insurance Trust, Inc.
  50 Hurt Plaza, Suite 1050
  Atlanta, GA 30303
  (404) 522-1501

- **Plan Eligibility Requirements and Summary of Benefits.**
  This booklet describes the benefits applicable to you under the Plan. For a description of the eligibility requirements of the plan, the type of benefits available, and the circumstances under which benefits of the plan are not available or may terminate, please refer to this booklet.

- **Claims Procedures.**
  For a description of how to file a claim, see the claims and general information section of this booklet.

- **Review of Claim Denial.**
  If your claim is denied, you or your authorized representative will receive a written notice stating the basis for the denial. You will then be entitled, upon written request, to review of claim decision. If you are not notified at all within 90 days after you submit the claim, this may be considered a claim denial and you may request a review as described above. Your request for a review must be submitted within 60 days after the claim is denied. The request should be accompanied by any documents or records in support of your appeal. A decision on the request will be made in writing within 60 days after it is received, except that if special circumstances require an extension of time, you will be so notified. In no event will a final decision on your claim be rendered more than 120 days after the request for review. The final decision should be in writing to the claimant, with reference to the relevant plan provision on which the decision was based. The insurance company has the right to interpret the plan provisions, so its decision is conclusive and binding.

  More information regarding this review procedure can be obtained from Greater Georgia Life, Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., or the employer.

- **Loss of Benefits; Modification of the Plan.**
  This booklet describes the events which may cause all or part of the coverage under the plan to terminate, and any rights you may have at such termination.

  One such event is termination of Blue Cross Blue Shield Healthcare Plan of Georgia Contracts which will result in the following:

  Termination of that part of the Plan's healthcare expense coverage for which BCBSHP has liability in accordance with the Group Contract Terms.

  If the Group Contract terminates the Plan's benefits, to the extent they were provided under it, will also terminate unless the Employer modifies the Plan to provide those benefits from another source.

  The BCBSHP Contract will terminate at the end of the grace period for an unpaid Premium, at any earlier date requested by the Employer, or (at BCBSHP's Option) when the number of covered Employees falls below any minimums in the Group Contract. In the case of the Group's Contract's health care expenses coverage, the part if the Group Contract Providing those coverage will end if the benefits provided directly by the Employer end or are substantially changed.

  Georgia Bankers Association Insurance Trust, Inc. expects to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan, or any part of it, at any time without the consent of persons covered under it. Amendment or termination of the Plan shall be made by the Directors of the Georgia Bankers Association Insurance Trust, Inc. However, any part of the Plan provided under the Group Contract issued by BCBSHP cannot be changed without BCBSHP's consent.

The plan shall not give any Employee or any Dependent of any Employee, any right or claim except to the extent that such right or claim specifically fixed under the terms of the plan. The establishment of the plan shall not be construed to give any Employee a right to be continued in the employ of the employer or as interfering with the right of the employer to terminate the employment of any Employee at any time.