BlueChoice

Healthcare Plan

Certificate Booklet

POS

HSA COMPATIBLE HIGH DEDUCTIBLE HEALTH PLAN

GBA | INSURANCE TRUST
GEORGIA BANKERS ASSOCIATION
the resource that empowers

Plan Options 481, 482

Effective January 1, 2015

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

BlueCross BlueShield of Georgia

CERTIFICATE OF COVERAGE

BLUE CHOICE POS PLAN

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, the Trust Adoption Agreement executed by each participating Employer, and any amendments or riders) constitutes the entire Contract. (The Group Master Contract may be referred to as the “Contract” or the “Plan” in this booklet. All rights which may exist arise from and are governed by this 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, Inc. The words “you”, and “your” refer to the Member, Subscriber and each Covered Dependent. The term “Plan Administrator” means the Georgia Bankers Association Insurance Trust, Inc.

Table of Contents

Summary of Benefits and Coverage

Please see the Summary of Benefits and Coverage (SBC) for a summary of Plan benefits, including:

- **Deductibles**
- **Copayments**
- **Coinsurance**
- **Out-of-pocket limits**
- **Limitations and restrictions on benefits**

For a copy of the Summary of Benefits and Coverage for this Plan, go to:
http://www.gabankers.com/WCM/Insurance___Retirement/Plan_Info/WCM/Insurance___Retirement/GBA_Insurance_Trust/Medical%20Plans.aspx?hkey=0a614eef-91de-4b49-b6e2-5c739cd29929**.**

You can also request a copy of the SBC for the Plan from your Human Resources director.

NOTE: You will need to know the number of your Plan option (481, 482, etc.) in order to find the correct SBC. If you are not sure of your Plan option, contact your Human Resource Department or call Member Services.

Your Plan at a Glance

This Certificate Booklet summarizes your Employer's health care benefit program. This Certificate Booklet is written in easy-to-read language to help you and your Dependents understand your health care benefits. The Plan's "**Summary of Benefits and Coverage**", or "**SBC**" summarizes, in chart form, your out-of-pocket costs and certain benefit limitations. In addition, certain administrative details and legal rights provisions are included in separate documents which are held by the Plan Administrator. Together, these documents make up the Plan document and govern 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 the Member Services Department.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente: 800-277-9218 opt#3 .
English translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the Member Services number: 800-277-9218 opt#3.

Your Benefits
The Plan pays the majority of your medical costs for Covered Services that you receive from our extensive network of In-Network Physicians, Hospitals and other healthcare Providers. **You do not need to get a referral from your primary care physician to see other healthcare providers in our network.**

The Plan also covers most prescription drug costs.

The Plan does not pay benefits for services that are not Medically Necessary; Provider charges that exceed the Maximum Allowed Amount; or certain services that are not approved in advance.

Your Out-of-Pocket Costs
You share in some of the costs of your care. These costs may include:

- **Copayments.** Copayments are charges that usually need to be paid at the time services are rendered by an In-Network Provider, and they are usually flat dollar amounts (such as a $50 charge for an office visit). Copayments must be paid even if you have met your deductible. Your copayment amounts are shown on the **SBC.**
- **Coinsurance.** The Plan determines the "Maximum Allowed Amount" that it will pay for Covered Services. "Coinsurance" is the percentage of the Maximum Allowed Amount that is paid by you and the Plan. For example, if your coinsurance amount is 20%, the Plan's coinsurance will be 80%. Your coinsurance amount for various healthcare services is shown on the **SBC.**
- **Deductibles.** A deductible is the dollar amount that you must pay each year or for a particular service before the Plan begins to pay benefits. For example, if you have a $500 calendar year deductible, the Plan will begin to pay benefits for Covered Services after you have paid $500 for Covered Services. If the deductible applies to you, it will be shown on the **Schedule of Benefits**. Your out-of-pocket costs for Covered Services received in the last three months of a calendar year which are applied to that year's Deductible will carry over and also be applied toward the next year's Deductible. This provision does not apply to the Prescription Drug deductible, which only applies if you receive a brand name drug when a generic equivalent is available.

The Limit on Your Out-of-Pocket Costs
The amount you must pay for Covered Services each year is capped as shown in the **SBC.** This limit is called the "**Out-of-Pocket limit."** Once you have paid this amount for Covered Services during the year, the Plan will begin to pay 100% of the Maximum Allowed Amount for Covered Services for the rest of the year. Your Deductibles, Coinsurance and Copayments are all counted in determining when you have met this Out-of-Pocket limit. Bear in mind that you may have

some out-of-pocket costs that are not counted toward the Out-of-Pocket limit. These excluded costs are also shown on the **SBC.**

Prior Approval
Certain health care services and supplies must be approved in advance in order for them to be covered. **If you do not get prior approval when it is required, your costs will not be covered by the Plan.** Approval is required for all inpatient admissions and many outpatient procedures. (See the section titled "Prior Approval Requirements.") Prior approval is also required for Specialty Drugs. (See the section titled "Prescription Drug Program.")

The procedures that require prior approval change frequently because of rapid changes in medical technology. Call Member Services **before** you receive the treatment to make sure that it will be covered. If you need prior approval for a prescription drug, contact the Pharmacy Customer Service line. Both of these numbers are shown below.

Be aware that getting prior approval does not guarantee payment of your claim. Payment may be denied, for example, if you are not eligible for Plan coverage when the service is provided.

Verification of Benefits

Authorized healthcare Providers may call Member Services on your behalf to verify that your Plan covers certain types of benefits. This verification does NOT satisfy the prior approval requirements and is NOT a guarantee of payment.

About Health Savings Accounts

This high deductible plan option 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: The Plan Administrator and Blue Cross and Blue Shield of Georgia do NOT provide tax advice. The Georgia Insurance Department does NOT in any way warrant that this policy meets the federal requirements. 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.

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.

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.
Important Contact Information

Claims Administrator:

Paragon Benefits, Inc.
Phone: 1-706-321-0209
Fax: 1-706-256-4089

Member Service:

Paragon Benefits
1-706-321-0209
www.paragonbenefits.com

Pharmacy Benefit Manager: Magellan Health (formerly known as PartnersRx)
Pharmacy Customer Service
1-855-856-0539
www.magellanhealth.com

Prior Approval, including Pre-Admission Certification (PAC), Outpatient Pre-Certification and Utilization Review
American Health Holdings, Inc:
1-877-417-3363

For prior approval of prescription drugs:
Contact Dawn Streetman at American Health Holdings, Inc.
1- 614-933-6714
or Dstreetman@ahhinc.com

Or contact
Nan Smith at 1-678-428-0916

24/7 Nurseline
A 7-day-a-week, 24-hour-a-day service is available for all covered family Members. When you or a covered family Member is experiencing health symptoms, you may call 24/7 Nurseline to speak to a registered nurse. The nurse will provide information to help you decide on the most appropriate treatment or care. You may also listen to a variety of medical audiotapes or request written information on a variety of conditions.

- 1-888-724-2583

Eligibility, Enrollment and Termination Provisions

Eligibility Requirements for Employee Coverage.

The following Employees will be eligible for coverage under this Plan:

New Hires:

- Regular Full-Time Employees: Employees designated by the Employer as Regular Full-Time Employees. Coverage for Regular Full-Time Employees will be effective on the first day of the month following completion of the Waiting Period, subject to completion of enrollment requirements. The Waiting Period is described in your Employer's Offer of Coverage.
- Regular Part-Time Employees: Regular Part-Time Employees are employees who are regularly scheduled to work less than 30 hours per week. If your Employer offers coverage to Regular Part-Time Employees, your Employer will establish the minimum weekly or monthly hours you must work to be eligible for this coverage. In addition, you must first complete 600 Hours of Service before becoming eligible. This requirement is in addition to any Waiting Period established by the Employer. If your Employer offers coverage to Regular Part-Time Employees, the hour requirements and any Waiting Period will be reflected on your Offer of Coverage. Coverage will be effective on the first day of the calendar month following completion of 600 Hours of Service and any Waiting Period, subject to completion of enrollment requirements.
- Qualifying Employee: A Qualifying Employee is an Employee who is not a Regular Full-Time Employee but who averages at least 30 Hours of Service per week over the Employee's Initial Measurement Period. Coverage will be effective on the first day of the Qualifying Employee's New Employee Stability Period, subject to completion of enrollment requirements. A Qualifying Employee will remain eligible throughout the New Employee Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service rules.

Note: if there is a gap between the end of the Qualifying Employee's New Employee Stability Period and the start of the Qualifying Employee's first Ongoing Employee Stability Period (see below), the Qualifying Employee will remain eligible under the Plan until the day preceding the start of the Ongoing Employee Stability Period (to the extent the employee remains employed, and subject to the Plan's Break in Service rules.)

If a Qualifying Employee transfers to a Regular Full-Time Employee position prior to the start of the Qualifying Employee's New Employee Stability Period, the Employee will become eligible for coverage. If elected, coverage for such new Regular Full-Time Employee will become eligible on the first day of the month following completion of the Waiting Period, subject to completion of the enrollment requirements.

Ongoing Employees:

Once an Employee has completed the Plan's Initial Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period (which is the calendar year), provided that the Ongoing Employee remains employed, and subject to the Plan's Break in Service rules. Coverage will be effective on the first day of the next calendar year, subject to completion of the enrollment requirements.

Impact of Breaks in Service

If you have a Break in Service and then return to work, you will be treated as a New Hire, and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. However, if you are not actively at work for a period and return to work or are otherwise credited with Hours of Service before you incur a Break in Service, you will be treated as a continuous employee and will be eligible for coverage under the Plan upon return if you were enrolled in coverage prior to the start of the period with no Hours of Service. Your coverage will be effective on the first day of the month that coincides with or follows the date you resume Hours of Service, subject to completion of enrollment requirements.

Eligible Classes of Dependents.

Your Employer's Offer of Coverage to this booklet will tell you if your Spouse or children are eligible for coverage. The definition of these terms is below:

- A covered Employee's Spouse.
  The term "Spouse" shall mean the person recognized as the Employee's husband or wife under the laws of the State where the employee was married, but does not include: common law spouses; a spouse from whom the Employee is legally separated; or same sex spouses.

- A covered Employee's Child(ren).
  An Employee's "Child" includes his natural child, stepchild, foster child, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When a child who is covered under the Plan reaches the limiting age, coverage will end on the last day of the Child's birthday month.

  The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

  Any Child of an Employee who is an alternate recipient under a qualified medical child support order that requires the Employee to provide health insurance shall be considered an eligible Dependent. An Employee may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

- A child for whom the covered Employee is a Legal Guardian.
  To be eligible for Dependent coverage under the Plan, the Employee or Spouse must be appointed as the child's legal guardian by valid court process, and the child must be under the limiting age of 26 years and primarily dependent upon the Employee or Spouse for support and maintenance. Eligibility will end on the last day of the month in which the Employee or Spouse ceases to be the child's Legal Guardian.

- A Totally Disabled Child.
  A covered DependentChild who is totally disabled may continue to be eligible beyond the limiting age if he is totally disabled on the date of his 26th birthday. A child is considered to be total disabled if he is incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered

Employee for support and maintenance and unmarried. The covered Employee must notify the Plan Administrator and give evidence of the disability within 30 days of the Child attaining age 26. The Plan Administrator may require annually, continuing proof of the total disability and dependency, and may require the Dependent to be examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity. Eligibility will end if the Dependent ceases to be totally disabled.

- Ineligible Dependents.
  These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; a foster child if one or both of the child's natural or adoptive parents live with the Employee, or if the foster child has been placed with the Employee under a welfare arrangement and the welfare agency pays all or part of the child's support; the legally separated or divorced former Spouse of the Employee; any person who is permanently residing outside the United States; or any person who is covered under the Plan as an Employee.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage.
A family member of an Employee will become eligible for Dependent coverage on the first day that (1) the Employee is eligible for and covered under Employee coverage and (2) the family member satisfies the requirements for Dependent coverage described above. A covered Employee's newborn or newly adopted child will be covered as the Employee's Dependent for 31 days following the date of birth or placement of adoption. This coverage will terminate after that date unless the Employee enrolls the child and pays all required premiums within the 31-day period.

The Plan Administrator may require proof that a spouse or child qualifies or continues to qualify as a Dependent as defined by this Plan. Such proof may include (but is not limited to) marriage licenses, birth certificates, tax records, relevant legal proceedings respecting marital status, guardianship and parental rights; and proof of joint residency. Failure to provide such documentation upon request is grounds for termination of coverage.

Enrollment Requirements.
An Employee must enroll for coverage by completing, signing (or electronically authorizing) and submitting an enrollment application within 30 days of the date he or she first becomes eligible for coverage. Otherwise eligible dependents will not be covered unless the Employee enrolls for Dependent coverage also. If an Employee and/or his or her Dependents are not enrolled on a timely basis, they may not enroll until the next open enrollment period unless a qualifying event occurs. In that case, the Employee and/or Dependents may be eligible to enroll under one of the Special Enrollment rights described below.

Special Enrollment Rights
Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

Special enrollment periods. The events described below may create a right to enroll in the Plan under a Special Enrollment right if all of the requirements are met.

- **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and the loss of coverage meets all of the following conditions:

  (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

  (b) The Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

  (c) Either (1) the other coverage was COBRA coverage, and the COBRA coverage was exhausted, or (2) the other coverage was not COBRA coverage, and the coverage was terminated because of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

  (d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage.

  (e) Coverage will begin as of the first day of the first calendar month following the date the other coverage ended.

  For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

  (f) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

  (g) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

  (h) The other coverage was offered through an HMO or other arrangement that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual.) However, these circumstances will not qualify as a loss of eligibility if the other coverage is offered under a group plan or through the group insurance market, and another benefit package is available to the individual.

  If the Employee or Dependent loses the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan), that individual does not have a Special Enrollment right.

- **Newly Eligible Dependents.** If:

(a) The Employee is covered under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In addition, the Spouse and other Dependent Children of the covered Employee may be enrolled as Dependents if they are otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll during this Special Enrollment Period in order for his eligible Dependents to enroll.

The New Dependent Special Enrollment Period is a period of 30 days and begins on the day after the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Employee must request enrollment for himself and/or his Dependents during this 30-day period.
The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:
(d) in the case of marriage, the first day of the first month beginning after the date of the marriage;
(e) in the case of a Dependent's birth, as of the date of birth; or
(f) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

- **Medicaid and State Child Health Insurance Programs.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

  (a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after the date such Medicaid or CHIP coverage is terminated.
  (b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance described in (a) or (b).

  If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll. Coverage will become effective as of the first day of the first calendar month following the date of the event

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- The eligibility requirement, including any Waiting Period;
- The active employee requirement; and
- The enrollment requirements.

Active Employee Requirement.

An Employee must be an active employee for this coverage to take effect. If an Employee is not actively at work on the date his or her coverage is to become effective, the coverage effective date will be postponed until the date the Employee returns to active status. However, if the Employee is not actively at work due to health status, this delay in effective date will not apply.

On occasion, when an Employer begins to offer coverage under this Plan, if an Employee or Dependent had coverage under a prior carrier and is covered under an extension of benefits provision, the Employee or Dependent (if otherwise eligible) will be enrolled in this Plan but the prior carrier will be responsible for payment of benefits and services related to disabilities in accordance with the terms of that carrier's coverage and applicable state law. To the extent these expenses are not covered under the prior carrier's coverage, this Plan will pay benefits in accordance with its own terms and conditions.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the same day as the Employee's coverage becomes effective, provided the Dependent Eligibility Requirements and all Enrollment Requirements have been met.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of the dates below. (However, in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section titled Continuation of Coverage – Federal Law(COBRA)):

- The date the Plan is terminated.
- The date the covered Employee's Eligible Class is eliminated.
- The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of active employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, coverage may be terminated as described below.

Continuation during Family and Medical Leave. Regardless of the established leave policies mentioned below, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan for the period of the FMLA Leave on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period. Coverage extended under this provision will continue until the end of the month in which the leave ends.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave and completes all application requirements. Coverage will be reinstated only if the person(s) had coverage under this

Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff. If a covered Employee ceases to be an active employee and is granted a leave of absence under his or her Employer's regular leave policies, coverage under the Plan may continue (if the Employer's leave of absence policy provides for continuance) until:

For leaves connected with maternity (in cases where the FMLA does not apply): the date the Employer ends the continuance, or, if sooner, 6 weeks following the birth or end of the pregnancy.

For authorized medical leaves of absence: the date the Employer ends the continuance, or, if sooner, 6 months following the date on which the person last worked as an active employee.

While continued, coverage will be that which was in force on the last day worked as an active employee. However, if benefits are reduced for others in the class, they will also reduce for the continued person. If the Employee does not return to active employment when the leave of absence ends, coverage will terminate on the last day of the month in which the leave ends. If you continue your coverage under COBRA following the leave of absence, the termination of the leave of absence (rather than your last day of active employment) will be treated as the date of your COBRA qualifying event (see "Continuation of Coverage – Federal Law(COBRA)").

Rehiring a Terminated Employee. To the extent permitted by applicable law, a terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period, at the employer's discretion.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- The maximum period of coverage of an Employee and his Dependents under such an election shall be the lesser of:
  (a) The 24 month period beginning on the date on which the Employee's absence begins; or
  (b) The day after the date on which the Employee was required to apply for or return to a position of employment and fails to do so.
- An Employee who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is

concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and his Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of the dates below. (However, in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation of Coverage – Federal Law (COBRA)):

- The date the Plan or Dependent coverage under the Plan is terminated.
- The date the Employer terminates participation in the Plan.
- The date that the Employee's coverage under the Plan terminates. However, coverage may be extended if a covered Employee dies while still employed by the Group. In that case, coverage for the Employee's Spouse, if covered at the time of Employee's death, may continue until the beginning of the month in which he or she reaches age 65, or if earlier, at the end of the month in which he or she remarries. Coverage for the Employee's covered Dependent children will terminate at the end of the month in which the child ceases to meet the eligibility requirements for a Dependent child as described above. Continuation of coverage will be subject to timely payment of any required premium contributions. You must notify the Plan Administrator at the time of the death, as different coverage options may apply. You may also be eligible to elect COBRA coverage at that time.
- The last day of the month in which the Dependent ceases to meet the applicable dependent eligibility requirements, including reaching the limiting age, divorce, or loss of legal guardianship or totally disabled status.
- If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, coverage may be terminated as described below.

The Employer or Plan Administrator has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan Administrator may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Plan Administrator reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Group Coverage Terminates. The Plan Administrator may cancel your Employer's participation (and your coverage) in the Plan in the event of any of the following:

- Your Employer fails to pay premiums in accordance with the terms of this Plan.
- Your Employer performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.
- Your Employer has fallen below our minimum employer contribution or employer participation rules. We will submit a written notice to the Employer and provide 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 under a particular policy form, provided that;

- We offer the Employer and 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.

Continuation of Hospital Benefits. If a covered Employee or covered Spouse or Dependent Child is receiving care in the Hospital at the time coverage is terminated for reasons other than the termination of Employer's participation in the Plan or for failure to timely pay premium contributions, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

How Your Benefits Work For You

Note: Capitalized terms such as Covered Services, Medical Necessity and In-Network Hospitals are defined in the "Definitions" section.

Introduction
This Plan is a comprehensive plan that provides Primary and Specialist health care services. The Plan 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 payment 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.

When You Are Away From Home
If you are away from the Service Area on business or pleasure, you still have coverage for Medical Emergencies. If you have a Medical Emergency, go to the nearest Hospital emergency room for treatment. If you are receiving care outside of Georgia, you will receive benefits at the In-Network level if you select a POS Provider in the state where you are located. You may find POS Providers by going to the Anthem website, www.anthem.com, or calling Member Services and a representative will assist you.

If you are outside the Service Area or Country, you will have to pay for any treatment you receive. We will reimburse you except for any required Copayment or Out-of-Pocket amount. However, for treatments outside the country, the Plan only pays benefits for medical emergencies or urgent care services. Other services you receive outside the country are not covered. You will need a copy of any bills translated into English. Call Member Service as soon as it's convenient and one of the representatives will tell you what you should do.

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

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, dietitian, Physician's assistant or Hospital) for specified Coverage Services. Such nominated Providers must be approved in writing by Blue Cross and Blue Shield of Georgia, Inc.and are subject to the normal rules and conditions which apply to a contracted 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 Network or Non-Network Providers, and other internal procedures which Blue Cross and Blue Shield of Georgia, Inc. normally follows. All Non-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 Blue Cross and Blue Shield of Georgia, Inc.'s rigorous credentialing process, and they are not subject to Blue Cross and Blue Shield of Georgia, Inc.'s quality assurance standards.

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

What Your Program Pays

Introduction: 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 that you receive.

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

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

You will be required to pay a portion of the Maximum Allowed Amount to the extent that you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network or Non-Preferred Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. 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 the full Coinsurance rate 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 an 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 Member Services for help in finding an In-Network Provider or visit **www.anthem.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 other 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 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 Member Services for help in finding an In-Network Provider or visit our website at **www.anthem.com**.

Member Services 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 Member Services 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 Providers. Please see the SBC and the "Your Benefits at a Glance"

section in this Certificate Booklet for your cost share responsibilities and limitations, or call Member Services to learn how this plan's benefits or cost share amounts may vary by the type of Provider you use.

The Plan will not provide any reimbursement for Non-Covered Services. You will 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 may also 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 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 service 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 service 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 Service, 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 Member Services 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 Member Services 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.

Let's say 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. 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 the Plan 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.

Prior Approval Requirements

As explained in the "Your Plan at a Glance" section, you must get prior approval for many procedures in order for them to be covered benefits. Because of rapidly changing medical technology, it is not possible to list all of these procedures. You should call Member Services to find out if prior approval is required if your healthcare Provider recommends any of the following:

- Inpatient hospitalization (except hospitalizations for birth/delivery)
- Outpatient surgery
- Outpatient diagnostic procedures, therapies and treatments
- Durable medical equipment
- Hospice
- Home health care
- Case management
- Specialty drugs

Inpatient Pre-Admission Certification (PAC)

Prior approval is always required for inpatient hospital admissions. This type of prior approval is called "pre-admission certification" or "PAC."

- PAC is required for **ALL** Hospital admissions except emergency or maternity delivery admissions. Please notify us within 48 hours of an emergency or maternity admission.
- PAC is also required for certain outpatient services listed later in this booklet. 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.

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.

The Pre-Admission Certification Process includes the following procedures:

- Length-of-Stay Assignment to indicate 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: 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 Physician or Specialist guidelines are followed, you will not be responsible for any eligible Hospital charge in excess of any applicable Deductible, Copayment or Coinsurance amounts;
- Admission Review to determine whether an unscheduled Inpatient admission or 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 a Medical Emergency or maternity delivery admission, and Pre-Admission Certification was not obtained, all charges will be denied. Ineligible Charges and Non-Covered Services are always the Member's responsibility.
- 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 and the Member.

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, 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 Plan will not cover services related to specific Contract exclusions and limitations, including but not limited to, Custodial Care, Experimental and Investigational procedures 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

- Photocoagulation of macular drusen
- Plantar fasciitis and plantar fibroma, cryoablation
- Reconstructive Surgery
- Skilled Nursing
- Sleep Studies
- Transplant Evaluation – 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. If you have any questions regarding these prior approval requirements, please contact Member Services at the number listed on your ID card.

Benefits

All Covered Services must be Medically Necessary.

Allergy Conditions
Benefits are provided as stated in the **SBC**.

Ambulance Services
Local service to the nearest appropriate facility 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 if Medically Necessary.

Attention Deficit Disorder (Medical Treatment of)
Office visits for an initial assessment and for maintenance treatment. Drugs prescribed by your Physician will be covered only in accordance with the Prescription Drug program benefits.

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.

Chiropractic Care
Covered Services for In-Network Spinal Manipulation are available **only** if stated in the **SBC**.

Clinical Trial Programs
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" means those pre-certified as Medically Necessary costs as provided in Georgia law (OCGA 33-24-59.1), or
- An approved clinical trial to treat a Qualified Individual with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, the cost of the trial drugs or procedures or charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Colorectal Cancer Examinations and Laboratory Tests
Covered Services include colorectal cancer screening 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.

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, 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 as 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. Benefits for insulin prescribed by a Physician are described under the Prescription Drug program.

Dialysis Treatment
Dialysis treatment is covered if care has been pre-certified by and coordinated through your Physician. After 30 months, benefits payable will not exceed the amount the Plan would pay secondary to Medicare Part B, 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 Member'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 must also state the length of time the equipment will be required. We may require proof at any time of the continuing Medical Necessity of any item; and
- It is related to the patient's physical disorder.

Emergency Room Services/Emergency Medical Services
Benefits are provided for initial services rendered for the onset of symptoms for Medical Emergencies including a life-threatening medical condition or serious Accidental Injury which requires immediate medical care. **Benefits are NOT provided for services provided at an emergency room for conditions that are not Medical Emergencies.**

- Life-threatening emergency care or treatment is covered on a 24-hour basis at any Hospital emergency room. Go to the nearest Hospital emergency room if you experience a life-threatening medical emergency.
- The emergency room Copayment is required for initial services for medical emergencies rendered in the emergency room of a Hospital.
- The Copayment is waived if a Member is admitted to the Hospital through the emergency room.
- Covered Services for medical emergencies include Medically Necessary mental health and substance abuse emergency care provided in the emergency room.

Coverage is provided for Hospital emergency room care for initial services rendered on 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 function; 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 the Member's care and treatment in the home. Your coverage is outlined in the **SBC**. 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.

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 Include:

- Visits by an RN or LPN.
- 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 Rehabilitation Services shown in the SBC.
- 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 the 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 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 Service

Hospice benefits cover Inpatient and outpatient services for patients certified by the attending Physician as terminally ill with a life expectancy of six months or less. Also, the Physician must design and recommend a Hospice Care Program. The Physician's statement and recommended program must be pre-authorized.

Your Contract provides Covered Services for Inpatient and outpatient Hospice care under certain conditions as stated in the **SBC**.

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 require treatment at an In-Network Hospital or Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Precertification is required for all Hospital admissions and certain outpatient Hospital services. The Plan provides Covered Services when the following services are Medically Necessary.

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.

Services and Supplies

- Services and supplies provided and billed by the Hospital while you are 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 Rehabilitation Services such as radiation therapy, speech therapy and occupational therapy are also covered.
- Convenience items (such as radios, TV's, CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Outpatient Services

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

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 casefinding;
- 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 Plan benefits.

The Plan Administrator (or its delegate, AHH) will determine 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 basis, depending on the plan of treatment, and may include Covered Services under the Plan.

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 maximum approved payments allowable under the program.

Benefits under the program are furnished as an alternative to other Plan 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 every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. We 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;
- transplants;
- conditions requiring Specialty Drugs;
- other cases at AHH's discretion.

Covered Services

- Services covered under individual case management will be determined by AHH at its 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.
- At the sole discretion of AHH, 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.

Utilization

- Benefits will be provided only when and for as long as AHH deems 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 that may be paid 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 AHH's 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 AHH 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 otherwise 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 Providers
Benefits are also payable for Covered Services provided by licensed Providers for services and supplies provided within the scope of the license. Such Providers include, but are not limited to, Nurse Practitioners (NP), Physician Assistant (PA), and Physician Assistant Anesthetists (PAA). The terms of the Plan will be applied in a manner that does not discriminate against a Provider who is acting within the scope of his or her license or other required credentials. However, this provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions or other limits, and does not require the Plan to accept all types of Providers as In-Network Providers.

Licensed Speech Therapist Services
Services must be ordered and supervised by a Physician. 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 recovery of the specific functional deficits identified.

Maternity Care
Covered Services include Maternity Care for the covered Spouse of an Employee. Covered Services include prenatal and postpartum visits as well as delivery and routine newborn nursery care. Routine newborn nursery care is part of the mother's maternity benefits. The newborn pediatrician visit in the Hospital is covered In-Network. Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name (see "Enrollment Requirements" and "Special Enrollment Rights"" to add coverage for a newborn).

Maternity benefits are not provided for Dependent children (including adults who are covered as Dependent children). However, certain Preventive Care services that are covered under the Plan will apply to pregnant women, and these services will be covered as required by applicable law.

Under federal law, the Plan may not restrict benefits for any hospital length of stay to less than 48 hours (following a vaginal delivery) or 96 hours (following a cesarean delivery) or require prior certification for either length of stay. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours following a cesarean section delivery). If discharge occurs earlier than the 48- or 96-hour period, 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 (In-Network)

Hospital Inpatient Mental Health Care & Substance Abuse Treatment. Benefits for Hospital and Physician Inpatient charges for each Member are stated in the **SBC**.

Hospital Inpatient Alcohol and Drug Detoxification. Benefits for acute alcohol and drug Detoxification for each Member in an In-Network Hospital are stated in the **SBC**. Benefits for professional fees for Inpatient Physician treatment of acute alcohol and drug Detoxification for each Member when administered by an In-Network Provider are stated in the **SBC**.

Professional Office Visits. Benefits for office visits (50-55 minute sessions or their equivalent) are stated in the **SBC.** Care must be given by a psychiatrist, psychologist, neuropsychologist, or a mid-level Provider such as a licensed clinical social worker, Mental Health clinical nurse specialist , or a licensed professional counselor.

Other Outpatient Care . Covered Services include professional care in the outpatient department of a Hospital. Prior authorization is required.

Nutritional Counseling
Nutritional counseling related to the medical management of certain diseases states (subject to pre-certification by AHH).

Nutritional Counseling for Obesity

Covered Services for obesity include services provided under Preventive Care benefits, which may 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 except to the extent provided under Preventive Care benefits.

Oral Surgery
Pre-certification is required.

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) and transplant related chemotherapy for cancer limited as described below. Benefits for antirejection drug treatment will be covered subject to the terms of the Prescription Drug program.

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 that is performed at a facility designated as a "Center of Excellence," a "Blue Distinction Center" or a "Global BlueCross Distinction Center." Due to rapid changes in medical technology, the list of covered transplants below may change frequently. An updated list is available by calling the pre-certification number shown at the beginning of this booklet.

- 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 transplant 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, State 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 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 blood 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 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 nontransplant related under the terms of this Plan.

"Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility designated as a "Center of Excellence," a "Blue Distinction Center" or a "Global BlueCross Distinction Center" 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 Medical Necessary services and supplies provided by a professional Provider in connection with a covered transplant except Donor Costs and antirejection drugs.

<u>Benefits for Antirejection Drugs</u>
For antirejection drugs following the covered transplant, Covered Services will be limited to Prescription Drugs, if any, otherwise covered under the Prescription Drug program.

<u>Pre-certification Requirements</u>
All transplant procedures must be pre-certified for type of transplant and be Medically Necessary and not Experimental or Investigational according to criteria established by AHH.

The pre-certification requirements are a part of the benefit administration of the Plan 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 designated as a "Center of Excellence," a "Blue Distinction Center" or a "Global BlueCross Distinction Center." Transplants performed at other facilities are not covered. 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 Plan, payment for the Member and the donor will be made under each Member's Coverage.
- If the donor is covered under this Contract, payment for the Member and the donor will be made under this Plan 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 Plan, payment for the Member will be made under this Plan limited by any payment which might be made by the recipient's Hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

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 the Plan criteria.

Other Covered Services
The Plan provides these Covered Services when Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, casts when provided by a covered 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 as shown in the SBC.

Outpatient CT Scans and MRIs
Pre-certification is required.

Outpatient Surgery
Medically Necessary services provided at a Hospital outpatient department or Freestanding Ambulatory Facility. Pre-certification may be required.

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
Services are limited to a combined total maximum visits per calendar year as outlined in the **SBC**. 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 any In-Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician.

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 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 shall meet requirements as determined by federal and state laws. 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 the Plan 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 Member Services using the number on your ID card for additional information about these services. Information is also available at these federal government web sites:

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

Private Duty Nursing Services
Pre-certification of Medical Necessity is required. Private duty nursing care by an RN or LPN will be covered on an inpatient basis when no intensive or cardiac care unit is available, and the care needed is beyond the capabilities of the Hospital's floor nurses. Benefits end when it is possible to move or transfer the patient to an intensive care or cardiac care unit.

Covered Services do not include services that:

- are requested by, or for the convenience of, the patient or the patient's family;
- consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving oral medication, or acting as a companion or sitter;
- are provided by a nurse who is a relative by blood or marriage or a member of the household of the Member;
- that could have been rendered by the Hospital's general nursing staff.

Prosthetic Appliances
Prosthetic devices to improve or correct conditions resulting from an 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), and 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; or 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 service otherwise excluded in this Certificate Booklet. (See "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.

See "Breast Reconstructive Surgery" in this section for coverage following a mastectomy.

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.

Second Medical Opinion
Covered Services include a second medical opinion by a Network Physician with respect to any proposed surgical intervention or any medical care that is a Covered Service.

Skilled Nursing Facility Care
Benefits are provided as outlined in the **SBC**. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that are 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.

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 common 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 Coinsurance based upon his or her In-Network benefits.

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

Prescription Drug Program
The Prescription Drug Program under this Plan is administered by the pharmacy benefit manager listed in the front of this booklet. Your benefit design, as shown in the **Summary of Benefits,** will determine the Deductibles, Copayments or Coinsurance for drugs under the Prescription Drug program. The Prescription Drug Program provides coverage for drugs which, under federal law, may only be dispensed with a prescription written by a Physician or other licensed provider. Some drugs, including insulin, which can be obtained without a prescription or over the counter (OTC), will be covered under the Prescription Drug benefit only 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.

Drug Formulary
The Drug Formulary is a list of drugs that includes:

- drugs that are covered under the Prescription Drug Program;
- drugs that are not covered; and
- drugs that must be authorized in advance in order to be covered.

A Member or prospective Member shall be entitled upon request, to a copy of the Drug Formulary Guide, available through the Member Guide, available on the pharmacy benefit manager's website shown in the front of this booklet, or as a separate reprint.

The pharmacy benefit manager may modify the Drug Formulary from time to time to add or remove drugs, or to reclassify drugs as generic, preferred, non-preferred or not covered. Drugs will generally not be removed from the Formulary unless there are similar drugs that are Therapeutically/Clinically Equivalent. You will be notified in writing of drugs changing to non-preferred or non-covered status under the Formulary at least 30 days prior to the effective date of the change if you have had a prescription for the drug within the previous 12 months of coverage under this Plan.

Prior Authorization
Certain drugs will require prior authorization. In most cases, you will be informed at the pharmacy that your prescription requires prior authorization and the prior authorization will be performed by the pharmacy benefit manager. For certain drugs, the pharmacy benefit manager will refer the prior authorization review to AHH. For these drugs, you will need to contact AHH at 614-933-6714 or by email at Dstreetman@ahhinc.com to make sure they are covered. The prior authorization requirement applies to Specialty Drugs and Non-Formulary Drugs.

Specialty Drugs. Specialty Drugs are typically high cost drugs that may be administered orally, by injection or infusion, or which may require special handling such as temperature-controlled packaging and expedited delivery.

Specialty Drugs may include (but are not limited to):

- biotechnology products;
- orphan drugs used to treat rare diseases;
- high cost drugs that total greater than $4000 per prescription per month for oral medications or $4000 per prescription per month for injectable or infused drugs;
- injectable medications including infusions in any outpatient setting—physician's office, home, or clinic;

- drugs requiring ongoing frequent management or monitoring of the patient by clinician, such as dose adjustment, or drugs used to treat chronic and potentially life threatening diseases ;
- drugs which require specialized coordination, handling and distribution services to ensure appropriate medication administration; and

Because of the constant changes in approved medical treatments for specific diagnoses, the pharmacy benefit manager maintains a selected list of Specialty drugs and approved diagnoses. If you are not sure whether a drug that has been prescribed for you is a Specialty Drug that requires prior authorization, contact AHH at 614-933-6714 or by email at Dstreetman@ahhinc.com.

Specialty Drugs are available via mail order and are shipped directly to you or to a Network Provider. 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 Copayment and/or Coinsurance may be prorated to support the method of distribution and treatment. If your Physician or other licensed provider charges an administration fee for Specialty Drugs, that charge will not be covered under the Prescription Drug Program but may be a Covered Service under Medical Benefits.

Please note that Specialty Drugs may also be obtained from a local pharmacy that agrees to accept the same payment terms as the mail order pharmacy, although your portion of the payment will be based on out-of-network benefits.

Non-Formulary Drugs. You may also use the prior authorization process to request a drug that is not listed on the Formulary. Members may obtain, without penalty and in a timely fashion, specific drugs and medications not included in the Drug Formulary when:

- You have been taking or using the non-formulary prescription drug prior to its exclusion from the formulary and AHH determines, after consultation with the prescribing Physician, that the Drug Formulary's Therapeutic/Clinically Equivalent is or has been ineffective in the treatment of the patient's disease or condition; or
- The prescribing Physician determines that the Drug Formulary's Therapeutic/Clinically Equivalent drug causes, or is reasonably expected to cause, adverse or harmful reactions in the patient.

Generic Drugs

Should the Member, on his or her own accord, choose a Brand Name Drug over a Generic Drug, regardless of whether a Generic equivalent is available and even if the Physician orders the drug to be "dispensed as written," the Member will pay the Deductible, and once the Deductible is satisfied, any applicable Copayment for the Brand Name Drug as outlined in the **SBC**. It is the patient's responsibility to discuss the availability of a generic drug before the physician writes a prescription.

Mail Order

Maintenance drugs are available via mail order. To determine if a drug is considered a maintenance drug or requires prior authorization, please call Pharmacy Customer Service. If a particular drug is not on the list of maintenance drugs, then it is not available through the mail order service.

Be aware that pharmaceuticals received from a mail order distributor can also be obtained from any local pharmacy that agrees to accept the same payment terms as the mail order distributor.

Over-the-Counter Medications
While most Over-the-Counter (OTC) medications are not covered, there are some OTC medications that are covered at 100% if prescribed by your physician. These include insulin and other drugs and vitamins prescribed in conjunction with Preventive Care benefits as described in the Medical Benefits section. To obtain the list of approved OTC medications please call Pharmacy Customer Service.

Off-Label Drugs
When prescribed for an individual with a life-threatening or chronic and disabling condition or disease benefits are provided for the following:

- Off-Label Drugs where Medically Necessary
- Medically Necessary services associated with the administration of such a drug.

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

Flu Vaccines
Your plan will cover a flu vaccine with a $0 co-payment when the vaccine is obtained through a participating pharmacy and processed through your prescription benefit. When you go to the pharmacy for the vaccine please present your identification card for this benefit.

The following are not Covered Services under this Prescription Drug Program. Some of these services may be covered under the Medical Benefits section:

- Prescription drug products for any amount dispensed which exceeds the FDA clinically recommended dosing schedule;
- Prescription Drugs received through an Internet pharmacy Provider or mail order Provider except for our designated mail order Provider;
- Non-legend vitamins, except as prescribed in connection with Preventive Care benefits;
- Tobacco cessation products (including the use of Wellbutrin SR for this purpose), except as prescribed in connection with Preventive Care benefits;
- Over-the-counter items;
- Cosmetic drugs (for example, Propecia);
- Appetite suppressants (Anorexiants);
- Weight loss products;
- Diet supplements;
- Syringes (for use other than insulin) except when in coordination with an approved injectable;
- Non-contraceptive injectables (except with prior authorization);
- 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 of 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 by a Physician or licensed provider. However, some OTC drugs may be covered if a prescription order is presented at the time of purchase (see "Over-the-Counter Medications," above).
- 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 we determine are not consistent with the diagnosis;
- Prescription Drugs which we determine 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;
- Drugs that are specifically excluded from coverage under the Drug Formulary;
- Systemic dermatological drugs.

Exclusions

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 AHH, 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 educational testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Plan 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 AHH, 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, health 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-Ordered 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 Service in this Certificate Booklet.
- **Crime –** Injuries received while committing a crime.
- **Daily Room Charges –** Daily room charges while the Plan 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 (except impacted teeth); 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 booklet.
- **Drugs –** Any drug or other item which does not require a prescription, unless specifically listed as a Covered Service.
- **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 AHH determines do not meet the listed criteria.
- **Employer-Run Care –** Care given by a medical department or clinic run by your employer or the employer of your Spouse or other Dependent for the benefit of its employees and/or their dependents.
- **Experimental or Investigational –** Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in AHH's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service 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 service is prescribed as the most likely to prolong life. However, routine patient care costs may be covered in connection with Clinical Trials to the extent specifically listed as a Covered Service.
- **Failure to Keep a Scheduled Visit –** Charges for failure to keep a scheduled visit or for completion of claim 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 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 AHH, 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 situations.
- **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.
- **Maximum Allowed Amount –** Expenses in excess of the Maximum Allowed Amount as determined by BCBSGA.
- **Medical Records –** 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 –** Where the Plan is secondary payer to Medicare (or would be secondary if the Participant were covered under 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 to the extent provided under the Medicare Secondary Payer requirements, whether or not the Participant has enrolled in Medicare Part B. This means that the Plan will pay no more than it would be required to pay as a secondary or tertiary payor if Medicare Part B coverage was in effect.
- **Methadone –** Methadone, suboxone and similar drugs are excluded for coverage unless used to support active participation in behavioral therapy for the purposes of treating drug addiction. Coverage is excluded for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines
- **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-Covered Services –** Services that are not Covered Services under the Plan.

- **Non-Physician Care –** Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care Providers acting within the scope of their license 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 or in conjunction with Preventive Care services and listed under Covered Services.) 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 (except as specifically included in Preventive Care services), 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 Examination –** 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 the 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 U.S.) –** Non-emergency treatment received outside the United States performed without authorization. Medical tourism is specifically excluded.
- **Vision –** Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Eye Refractions. Services or devices to correct vision or for advice on such services.
- **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 of 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 BlueChoice Healthcare Plan Group program, BCBSGA program, any other group health plan or group medical expense coverage, or any local, state or governmental program (except school accident insurance coverage and Medicaid), then benefits payable under this Plan will be coordinated with the benefits payable under the other program. The total benefits paid by both programs will not exceed 100% of the Allowable Expense, the per diem negotiated fee 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:

- Automobile Insurance
  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.
- Non-Dependent/Dependent
  The benefits of the program which covers the person as other than a dependent, (for example, as an Employee) are determined before those of the program which covers the person as a Dependent.
- Dependent Child/Parents Not Separated or Divorced 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.

- Dependent Child/Parents Separated or Divorced
  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 a Member longer are determined before those of the program that covered that person for the shorter time. This includes a situation in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan.

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 Expenses 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 person we have paid or for whom we have paid,
  - insurance companies, or
  - other organizations.

Right of Recovery

- If you or a Covered Dependent 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, we shall have a right of recovery. Our 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. Our right of recovery shall include compromise settlements. You or your attorney must inform us of any legal action or settlement discussion, ten days prior to settlement or trial. We will then notify you of the amount we seek, and the amount of your legal expenses we 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 about 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 recover 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 Member

As a Member, you have the right to:

- Recommend changes to the Member's Rights and Responsibilities policy.
- Receive information about the Plan, its services, its Providers, and about your Rights and Responsibilities as a Member.
- Choose your personal Physician from the Plan's network directory listing In-Network Providers and change your personal Physician.
- 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.
- Understand where your consent is required and if you are unable to give consent, the Plan will seek your designated guardian and/or representative to provide this consent.
- Participate in full discussions 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 Plan including access to routine services, as well as after-hours and emergency services.
- Be informed of your deductibles, premiums, copayments, and any maximum limits on out-of-pocket expenses for items and services.
- Receive plan rules regarding Copayments 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). We encourage 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 capitation, 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 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 seeking specialty care, and pay any applicable Physician office Copayments at the time of service and Coinsurance or other Out-of-Pocket costs 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 us 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(s).

Balance Billing
Participating Physicians are prohibited from balance billing. A Participating Physician has signed an agreement with BCBSGA to accept our determination of the Usual, Customary and Reasonable Fee for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Plan, 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 and Payment of Claims In the event you submit a claim, to receive benefits, a properly completed claim form with any necessary reports and records must be filed within 90 days of the date of service. Payment of claims will be made as soon as possible following receipt of the claim. See the Section titled "Claims and Appeal Procedures" for more information on this process.

Necessary Information
In order to process your claim, the Plan Administrator 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.

We will consider such information confidential. However, we have the right to use this information to defend or explain a denied claim.

In-Network Providers
The Plan provides or makes payment for Medically Necessary covered health care services received by the Member. The health care services are subject to the limitations, exclusions, and Copayments specified in this booklet.

Unauthorized Use of Identification Card
If you permit a Plan 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 retroactive termination of the coverage.

Questions About Coverage or Claims
If you have questions about your coverage, contact your Plan Administrator or the Member Services 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 Member Services Department.

Write
Member Services Department
Paragon Benefits, Inc.
PO Box 12288
Columbus, GA 31917

When asking about a claim, give the following information:

- Member ID number;
- Patient name and address;
- Date of service; type of service rendered; and
- Provider name and address (Hospital or doctor).

We Want You to be Satisfied
We hope that you will always be satisfied with the level of service provided to you and your family. We realize, however, that there may be times when problems arise and miscommunications occur which lead to feelings of dissatisfaction.

Complaints about Blue Cross and Blue Shield of Georgia, Inc. Service
As a Member, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process established to ensure that we give our fullest attention to your concerns. Please utilize it to tell us when you are displeased with any aspect of services rendered.

- Call the Customer Service Department. The phone number is on your ID Card. Tell us your problem and we will work to resolve it for you as quickly as possible.
- If you are not satisfied with our 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 Member Services Representative at the number on your ID Card.
- If, depending on the nature of your complaint, you remain dissatisfied after receiving our response, you will be offered the right to appeal our 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 us.

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

Terms of Your Coverage
We provide the benefits described in this booklet only for eligible Members. The health care services are subject to the limitations, exclusions, deductibles, copayments, and percentage payable requirements specified in this booklet. Any Group BCBSGA Certificate which you received previously will be replaced by this Contract.

Benefit payment for Covered Services or supplies will be made either directly to the In-Network Provider or to you. However, this Plan and the Contract provide benefits only for covered Members and it does not create any third party beneficiary rights for any other party, including Providers.

Neither the Plan Administrator, your Employer, Paragon Benefits or BCBSGA is 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, we 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 Member Services or 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 us of your new address.

General Information
Fraudulent statements on Subscriber application forms and/or claims for services or payment involving any 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.

The Plan Administrator, 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.

We will adhere to the Employer's instructions and allow the Employer to meet all 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 we do not assume any responsibility for compliance.

Changes in Coverage
The Plan Administrator and BCBSGA may mutually agree to change the benefits described in this booklet. Fees charged for benefits described in this booklet may be changed from time to time.

Acts Beyond Reasonable Control (Force Majeure)
Should the performance of any act required by this coverage be prevented or delayed by reason or 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 us to use the Blue Cross and Blue Shield Service Marks in the state of Georgia, and that we are not contracting as the agent for the Association. The Member Group further acknowledges and agrees that it has not entered into this policy based upon representations 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 our 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.

Calculation of Coinsurance and Other Subscriber Liability
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 us.

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 specified 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 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 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 required a surcharge, BCBSGA would then calculate your liability for any covered health care 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-BLUE. 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 your Blue Cross and Blue Shield plan. If the required authorizations are not performed 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 medical emergency or urgent 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. We will reimburse you directly. Payment will be based on Covered Services and based on the Maximum Allowable 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 covered 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 covered Employees can remain on the Group's health plan and receive Group benefits as primary coverage.

Continuation of Coverage

A. 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.

Cost

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.

B. 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. This type of coverage is known as COBRA coverage.

(There may be options other than COBRA coverage available when you lose your Group coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.)

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 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
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction in Hours Worked	18 Months
For Spouses/Dependents: A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction in Hours Worked	18 Months
Covered Employee's Entitlement to Medicare	36 Months
Divorce or Legal Separation	36 Months
Death of a Covered Employee	36 Months
For Dependents: 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 qualified 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.

Second qualifying event

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 Plan Administrator within 30 days. You must notify the 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 Plan Administrator notified 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 employees, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for similarly situated employees, and it must be paid to the 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 by the Social Security Administration to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, at the time of the qualifying event, or 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 is covered under this Contract, and if he or she becomes absent from employment by reason of military leave, the Employee (and his or her Dependents, if covered) 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.The Employee can elect to continue coverage under this Plan 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 return to employment. 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.

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 does 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 Plan by reason of the Member's reinstatement of coverage.

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;

- a covered individual becomes entitled to Medicare after electing COBRA;
- the Group terminates all of its group welfare benefit plans. COBRA coverage will end under this Plan when the Group terminates its participation in this Plan, but may be continued under any new plan offered by the Group.

C. 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 contact;
- 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.

D. 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 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.

E. 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 Contact.

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

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.

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 any other cause) for care which the Member receives. It does not include Injuries for which benefits are provided under any Worker's Compensation, employer's liability or similar law.

After-Hours Office Visit
Care rendered as a result of a condition that has an onset after the Physician's business hours.

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 calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Brand Name Drugs
A drug item which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies. There are two types of Brand Name Drugs:

- Single Source Brand: those drugs that are produced by only one manufacturer and do not have a Generic equivalent available.
- Multi-Source Brand: those drugs that are produced by multiple pharmaceutical manufacturers and do have a Generic equivalent available on the market.

Break in Service
A period of at least 13 consecutive weeks during which the Employee has no Hours of Service. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves of Absence.)

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 a Contract 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 our legal obligation to the individual Members. It is part of this Certificate Booklet.

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
The percentage of costs that the Plan and the Member must pay for Covered Services. If the Plan limits its responsibility to a certain percentage, for example 80%, then the Plan's coinsurance amount is 80% and the remaining 20%, for which the Member is responsible, is the Member's Coinsurance amount.

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, and 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, cesarean section, occasional spotting, and 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 or Plan
This Certificate Booklet in conjunction with the Group Master Contract, your Identification Card and your Enrollment Application constitute the entire Plan. If there is any conflict between either this Certificate Booklet or the contracts and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Certificate Booklet and the contracts, the contracts shall control.

Contract Year
The calendar year.

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 claim 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.

Copayment
A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **SBC** for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Typical Copayments are fixed or variable flat amounts for Physician office visits, Prescription Drugs or Hospital services. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered. Copayments may be collected by the Provider of service.

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 Plan, and is subject to Premium requirements determined by the Plan Administrator.

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

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 requirements 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 do 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 service which, in the sole determination of the Plan Administrator 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.

Dependent
The spouse and children of a covered Employee who meet the eligibility requirements in the "Eligibility" section.

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.

Drug Formulary
A document setting forth certain rules relating to the coverage of pharmaceuticals that may include but not be limited to (1) a listing of preferred and non-preferred prescription medications that are covered and/or prioritized in order of preference, and (2) pre-certification rules. This list is subject to periodic review and modification by the pharmacy benefit manager at its sole discretion. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not listed as covered in the Drug Formulary.

Durable Medical Equipment

Equipment, as determined by AHH, 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; and (e) not for exercise or training.

Early Retiree
In order to qualify for early retiree benefits an employee must be at least 55 years of age but less than 65 years of age, have 10 years of service and not be actively working full time for the Employer. Early retiree benefits do not apply to an Early Retiree who is working part-time if the Employer offers coverage to part-time employees.

Effective Date
The date for which the Plan Administrator approves an individual application for coverage. For individuals who join an Employer after the first enrollment period, the Effective Date is the date the Plan Administrator 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 effect 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 as a common law employee with a participating Employer in the Group, and who is eligible for Group coverage under the Plan in accordance with the Plan rules and the employment regulations of the Employer.

Employer
A participating employer in the Georgia Bankers Association Insurance Trust Benefit Plan.

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 Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikus (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 Institute 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.

Generic Drugs
Prescription Drugs that are not Brand Name Drugs but which are made up of equivalent ingredients.

Group
The covered Employees' participating Employer, each of which has entered a Trust Adoption Agreement with the Plan Administrator. The Group shall act only as an agent of Members who are Subscribers of the Group and their eligible 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 Physician.

Home Health Care Agency
A Provider which 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 for cure for their illness.

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.

Hours of Service
Each hour for which the Employee is paid or entitled to payment for performance of services for the Employer and any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

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

Initial Measurement Period

The period of 12 calendar months beginning on the first day of the calendar month coinciding with or next following the Employee's date of hire. Notwithstanding the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration.

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 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.

Maternity Care
Obstetrical care received both before and after the 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
At 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 Care Facility, Chemical Dependency Treatment Facility, Skilled Nursing Care Facility, Home Health 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

The Plan Administrator or its designee 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.

A health care service is considered Medically Necessary if it is:

- appropriate and consistent with a 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 doctor, health care Provider or Hospital;
- not primarily Custodial Care; and
- provided in a safe and appropriate setting given the nature of the diagnosis and 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 of 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.

Mental Health Care Provider
An institution such as a Hospital or ambulatory care facility established for the diagnosis and treatment of mental illness. The facility must have diagnostic and therapeutic facilities for care and treatment provided by or under the supervision of a licensed Physician. The facility must be operated in accordance with the laws of the State of Georgia, or accredited by the Joint Commission on Accreditation of Hospitals.

New Employee Stability Period
The period of 12 calendar months that begins on the first day of the month following the month that begins on or after the Employee's anniversary date.

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.

Ongoing Employee Stability Period
The period of 12 calendar months that begins on the first day of each calendar year following the end of the Plan's Standard Measurement Period.

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 and supplies, that does not have a POS network Provider Contract with BCBSGA.

Out-of-Pocket Limit
The maximum amount of a Member's payments for Covered Services during a given calendar year. Such amount does not include charges for Non-Covered Services, penalties for failure to obtain prior authorization or pre-certification, or fees 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.

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. This service could be provided or prescribed, overseen and billed for by the Physician, or given by a physiotherapist on an Inpatient basis on the orders of a licensed Physician and billed by the Hospital.

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, and licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice Podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally authorized 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
Georgia Bankers Association Insurance Trust, Inc.

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 and which must be dispensed by a pharmacist.

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.

Psychiatric Services within a General Hospital Facility
A general Hospital facility that provides Inpatient Psychiatric Services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a Physician.

QMCSO – Qualified Medical Child Support Order
A QMCSO creates or recognizes a right of a child who is recognized under the order as having the 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.

Special Unpaid Leave of Absence
Any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer).

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. Specialty Drugs require prior authorization.

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 a Physician's office. These pharmacies also provide telephonic therapy management to ensure safety and compliance.

Spinal Manipulation
Correction of subluxations in the body to remove nerve interference or its effects. Interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Standard Measurement Period
The calendar year. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

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 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 on 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. "Therapeutic/Clinically 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 organization 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 an 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 **SBC**.

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 an organization or entity listed at the beginning of this booklet and selected by us 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

As a participant in the Plan, the Employee Retirement Income Security Act of 1974 (ERISA) entitles you to certain rights and protections, including the right 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 a copy of the latest annual report (Form 5500 Series) filed by this plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration;
- Obtain copies of all plan documents , including insurance contracts, the latest annual report and updated summary plan description, 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.

You also have the right to continue coverage under this Plan for yourself, your spouse or dependents under certain circumstances. This is called COBRA continuation coverage and is decribed in more detail in the "Continuation of Coverage" section of this booklet.

In addition to creating rights for plan participants, ERISA imposes duties on the people responsible for the operation of the 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 you submit a claim for Plan benefits that is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. These rules are described in the "Claims Procedures" section of this booklet.

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, and you have followed all of the procedures described in the "Claims Procedures" section, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, or a medical child support order, you may file suit in a 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 Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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 calendar year dollar limits, lifetime dollar limits, or day/visit limits on Mental Health or Substance Abuse benefits that are lower than that for medical and surgical benefits. The Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on Mental Health and Substance Abuse benefits that are more restrictive than Deductibles, Copayment/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 of 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 Copayments, Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the **SBC**.

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

Claims Procedures

This section describes how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures, both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the Final Adverse Benefit Determination.

The Claims Adminstrator makes the initial determinations of a claim. If the cliam is denied, in whole or in part, the claimant may appeal the decision of the Claims Administrator. The appealw ill be decided by the Claims Review Committee of the Plan Administrator. This Committee has full discretionary authority to interpret the terms of the Plan in making its final claims determinations on appeal. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator must decide whether to approve or deny the Claim. The Claims Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Claims Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Claims Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Claims Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Claims Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to predetermination of benefits, prior approval, pre-certification or mandatory second opinions.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	30 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Claims Review Committee shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Claims Review Committee issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Claims Review Committee shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Voluntary appeals

In addition to the Claims and Appeals Procedures described above, the Plan permits voluntary dispute resolution procedures. This may include informal discussions with the Claims Administrator or Claims Review Committee to resolve the dispute. If a claimant agrees in writing to use these procedures, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan will not assert that a claimant has failed to exhaust administrative remedies merely because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after receipt of a Final Adverse Benefit Determination.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

External Review Process

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. The External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Claims Review Committee will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Claims Review Committee will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Claims Review Committee will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the

claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

BlueChoice POS

Underwritten by Blue Cross Blue Shield
Healthcare Plan of Georgia, an Independent Licensee
of the Blue Cross and Blue Shield Association

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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. Your coverage amount may be based on a multiple of your annual salary (up to a maximum coverage amount of $350,000) or a flat dollar amount (such as $10,000, $25,000 or $50,000.)

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 children who are
    - Age 14 days to 26 years. You will be required to provide: a copy of the birth certificate naming you the parent or for a step-child naming your spouse as a parent. For an adopted or foster child you will need to provide a copy of the amended birth certificate or a copy of the adoption decree naming you as the parent/foster parent and a copy of a legal document showing the child's age.

Children include:

- Your children
- Step-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 personalized 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".

An employee may elect both basic and optional dependent life without providing proof of insurability if he enrolls within 31 days of first becoming eligible. If the employee elects dependent medical coverage, the basic dependent life coverage is mandatory and will automatically be provided. Optional dependent life will be issued only if the employee elects it.

If the employee does not elect dependent life when he first becomes eligible, evidence of insurability must be provided, except that basic dependent life will be issued without proof of insurability at any time the employee elects dependent medical coverage.

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 an active Employee attains age 70, the amount of Life and AD&D insurance showing in your personalized Summary of Benefits will be reduced to 30% of that amount. Coverage amounts will be rounded down to the nearest $1000 of coverage. For example, if your coverage amount is $50,000, the reduced coverage amount will be $15,000.If the amount of coverage is greater than $250,000, that amount will be reduced to $75,000. This benefit will not be further reduced unless you elect to reduce your coverage to $15,000 (see "Continuation after Retirement" below.)

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 basis; 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 life insurance purposes is a former Active Full-Time Employee of the Employer who:

- has completed at least 10 years of service;
- is at least 55 years of age; and
- is covered by this Term Life benefit on the date of retirement.

The amount of Life Insurance will depend on whether your coverage amount is based on a multiple of your salary or a flat dollar amount.

Coverage Amount Based on Salary. Beginning on the first of the month after you retire, the amount of Life Insurance will be equal to thirty (30) percent of the amount in effect on the day before the date of retirement. (If the amount of coverage in place on the day before retirement is greater than $250,000, then the amount of coverage following retirement will be reduced to $75,000.) You have the option to elect reduced coverage in the amount of $15,000 if you prefer.

Flat Dollar Coverage. Beginning on the first of the month after you retire, the amount of Life Insurance will be equal to thirty (30) percent of the amount in effect on the day before the date of retirement.

Coverage amounts will be rounded down to the nearest $1000 of coverage. For example, if your coverage amount is $50,000, the reduced coverage amount will be $15,000.

Accidental death and dismemberment benefits terminate on the last day of the month in which 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 within31 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 or 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 personalized 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 personalized 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.

Review of Claim Denial.
If your claim for life insurance benefits 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 and Blue Shield of Georgia, Inc., or the employer.

Plan Information

The purpose of this notice is to furnish you with certain information regarding this 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 Employees of the Participating Employers of the Georgia Bankers Association Insurance Trust, Inc.

- **Plan Sponsor.**
  Georgia Bankers Association Insurance Trust, Inc.

- **Plan Number.**
  58-2241094

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

- **Type of Plan.**
  The Plan provides health, dental, life, and disability coverage. This booklet describes the terms of coverage and benefits under the health and life insurance 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

- **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 and Blue Shield of Georgia, Inc. Contracts which will result in the following:

  > Termination of that part of the Plan's healthcare expense coverage for which BCBSGA 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 BCBSGA Contract will terminate at the end of the grace period for an unpaid Premium, at any earlier date requested by the Employer, or (at BCBSGA'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 BCBSGA cannot be changed without BCBSGA'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.