THE POS HEALTH BENEFITS PLAN
HSA COMPATIBLE
HIGH DEDUCTIBLE HEALTH PLAN

“Creating A More Educated Georgia”

THE UNIVERSITY SYSTEM OF GEORGIA

Plan Design – Effective January 1, 2012
Booklet Revised – January 2012
# RESOURCE CONTACTS

Should you have questions regarding your POS healthcare plan benefits, please contact the appropriate resource(s) identified below:

<table>
<thead>
<tr>
<th>For Questions About:</th>
<th>Please Contact</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims/Coverage Provided by the Plan</strong>&lt;br&gt;For information regarding the participating providers.</td>
<td>Campus Human Resources/Personnel Office&lt;br&gt;Blue Cross Blue Shield of Georgia</td>
<td>Your Institution&lt;br&gt;1-800-424-8950&lt;br&gt;TDD/404-842-8073</td>
</tr>
<tr>
<td><strong>BCBSGa Online Tools and Online Provider Directory</strong></td>
<td>Blue Cross Blue Shield of Georgia</td>
<td><a href="http://www.bcbsga.com">www.bcbsga.com</a> or <a href="http://www.bcbsga.com/bor">www.bcbsga.com/bor</a></td>
</tr>
<tr>
<td><strong>Pre-certification for Specific Outpatient/All Inpatient Hospital Services</strong></td>
<td>Blue Cross Blue Shield of Georgia</td>
<td>1-800-233-5765&lt;br&gt;TDD/1-800-368-4424</td>
</tr>
<tr>
<td><strong>24/7 NurseLine</strong>&lt;br&gt;For emergency room referral and for medical information from a registered nurse, 24-hours a day, seven days a week.</td>
<td>Blue Cross Blue Shield of Georgia</td>
<td>1-800-785-0006&lt;br&gt;TDD/1-800-368-4424</td>
</tr>
<tr>
<td><strong>360° Health Program</strong></td>
<td>Blue Cross Blue Shield of Georgia</td>
<td>1-800-785-0006&lt;br&gt;TDD/1-800-368-4424</td>
</tr>
<tr>
<td><strong>Centers of Excellence Transplant Program</strong></td>
<td>Blue Cross Blue Shield of Georgia</td>
<td>1-866-694-0724&lt;br&gt;TDD/1-800-368-4424</td>
</tr>
<tr>
<td><strong>Behavioral Health &amp; Substance Abuse Providers/Facilities</strong>&lt;br&gt;For information regarding the status, availability, and/or nomination of network providers/facilities, or, for obtaining pre-certification for benefits coverage.</td>
<td>Blue Cross Blue Shield of Georgia</td>
<td>Call the number located on your identification care.&lt;br&gt;TDD/404-842-8073</td>
</tr>
<tr>
<td><strong>HIPAA Coverage</strong></td>
<td>Secretary</td>
<td>U.S. Dept. of Health and Human Services&lt;br&gt;Office of Civil Rights, Region IV&lt;br&gt;61 Forsyth St. SW, Suite 3B70&lt;br&gt;Atlanta, GA 30303-8909&lt;br&gt;404-562-7886 (metro Atlanta)&lt;br&gt;1-866-627-7748 (outside of metro Atlanta)</td>
</tr>
</tbody>
</table>

University System of Georgia health benefits website: [www.usg.edu/hr/benefits/health_insurance/](http://www.usg.edu/hr/benefits/health_insurance/).
# TABLE OF CONTENTS

## YOUR HDHP POS HEALTH BENEFITS PLAN

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. About Health Savings Accounts</td>
<td>1</td>
</tr>
<tr>
<td>2. Introduction</td>
<td>2</td>
</tr>
<tr>
<td>3. Benefits at a Glance</td>
<td>3</td>
</tr>
<tr>
<td>13. Who Can Enroll</td>
<td>13</td>
</tr>
<tr>
<td>13. How to Enroll</td>
<td>13</td>
</tr>
<tr>
<td>13. Dependent Coverage</td>
<td>13</td>
</tr>
<tr>
<td>14. When Employee Coverage Begins</td>
<td>14</td>
</tr>
<tr>
<td>14. When Dependent Coverage Begins</td>
<td>14</td>
</tr>
<tr>
<td>15. Adding or Deleting Dependents</td>
<td>15</td>
</tr>
<tr>
<td>15. Change of Full-Time Student Status Upon Attainment of Age 26</td>
<td>15</td>
</tr>
<tr>
<td>16. USG Open Enrollment Period</td>
<td>16</td>
</tr>
<tr>
<td>16. The Cost of Your Healthcare Coverage</td>
<td>16</td>
</tr>
<tr>
<td>16. Qualifying Events for Changes in Healthcare Plan Coverage</td>
<td>16</td>
</tr>
<tr>
<td>18. Continuation of Healthcare Coverage Into Retirement</td>
<td>18</td>
</tr>
<tr>
<td>18. USG Retiree Annual Change Period</td>
<td>18</td>
</tr>
<tr>
<td>19. Qualifying Events for Changes in Retiree Healthcare Plan Coverage</td>
<td>19</td>
</tr>
<tr>
<td>20. Permissible USG Retiree Healthcare Plan Changes</td>
<td>20</td>
</tr>
<tr>
<td>21. The Annual Deductible</td>
<td>21</td>
</tr>
<tr>
<td>22. The Maximum Annual Out-Of-Pocket Limit (Stop Loss)</td>
<td>22</td>
</tr>
<tr>
<td>23. Administrative Agents/Business Associates</td>
<td>23</td>
</tr>
</tbody>
</table>

## HOW YOUR POS HEALTH BENEFITS PLAN WORKS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. What Your Program Pays</td>
<td>24</td>
</tr>
<tr>
<td>28. Pre-Admission Certification (PAC) and Outpatient Pre-Certification</td>
<td>28</td>
</tr>
<tr>
<td>31. Benefits</td>
<td>31</td>
</tr>
<tr>
<td>46. Mental Health and Substance Abuse Treatment</td>
<td>46</td>
</tr>
<tr>
<td>46. Prescription Drug Program</td>
<td>46</td>
</tr>
<tr>
<td>49. Newborn’s and Mother’s Health Protection Act of 1996</td>
<td>49</td>
</tr>
<tr>
<td>49. Women’s Health and Cancer Rights Act of 1998</td>
<td>49</td>
</tr>
<tr>
<td>49. 360° Health Programs</td>
<td>49</td>
</tr>
<tr>
<td>52. 24/7 NurseLine Program</td>
<td>52</td>
</tr>
<tr>
<td>53. Expenses the POS Healthcare Plan Does Not Cover (Exclusions)</td>
<td>53</td>
</tr>
<tr>
<td>59. When Your POS Healthcare Plan Coverage Ends</td>
<td>59</td>
</tr>
<tr>
<td>59. When POS Healthcare Plan Coverage for Your Eligible and Covered Dependent(s) Ends</td>
<td>59</td>
</tr>
<tr>
<td>60. Coverage For Active Employees Age 65 or Over</td>
<td>60</td>
</tr>
<tr>
<td>60. Coverage After Retirement</td>
<td>60</td>
</tr>
<tr>
<td>61. Extended Healthcare Coverage for Dependents After the Death of a Covered Employee</td>
<td>61</td>
</tr>
</tbody>
</table>
62 General Information Required to File a Claim
63 Filing Paper Claims/Foreign Claims While Traveling Abroad
64 Denial of a Medical Claim by BCBSGA
64 Appealing a Denied Claim
65 Assignment of Benefits
66 Right of Reimbursement

66 ADMINISTRATIVE INFORMATION

66 Coordination of Benefits (COB)
68 Your COBRA Rights
72 Health Insurance Portability and Accountability Act (HIPAA)
    Notice of Privacy Practices
78 Consent for Authorization for Use/Release of Health Information Form
80 Future of the Plan
80 Employment Rights Not Implied
80 Glossary of Terms

84 LEGISLATION PASSED BY THE 2008 GEORGIA GENERAL ASSEMBLY
    AND SIGNED BY THE GOVERNOR

84 HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW
About Health Savings Accounts

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

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

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

BCBSGA has designed this Contract to meet government requirements for an HSA compatible high Deductible health Contract to be used in conjunction with establishing eligibility for HSA tax benefits. Although BCBSGA believes that the Contract meets these requirements, the Internal Revenue Service has not ruled on whether the Contract is qualified as an HSA compatible high Deductible health Contract.
BOR Point of Service (POS) Health Benefits Plan Summary Document

YOUR POS HEALTH BENEFITS PLAN

INTRODUCTION

This booklet describes the Board of Regents POS Health Benefits Plan (the plan), available to employees and retirees of the University System of Georgia (the System), effective January 1, 2012.

Your health benefits plan is designed with two important goals in mind. The primary purpose of the healthcare plan is to provide you and your family with access to medical care in the event of an illness or serious injury. Your POS healthcare plan will offset member costs for medically necessary treatment of covered illnesses and/or injuries.

The second goal of the health benefits plan is to encourage covered members and their families to take an active role in decisions regarding their healthcare. That involvement begins with reading this booklet and with learning how the POS healthcare plan works. It is your responsibility to make efficient use of the coverage provided by the plan. Should you have questions regarding your benefits, as presented in this booklet, please contact your campus Human Resources/Personnel Office, or, the appropriate vendor. Vendors are listed on the inside front cover of this plan summary document.
BENEFITS AT A GLANCE

Provided for your information is a summary of selected benefits that are available to you and your family under the plan:

<table>
<thead>
<tr>
<th>SELECTED PLAN FEATURES AND COVERED SERVICES</th>
<th>PLAN PROVISIONS AND BENEFITS In-Network</th>
<th>PLAN PROVISIONS AND BENEFITS Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual – In-Network and Out-of-Network combined (single coverage)</td>
<td></td>
<td>$1,500*</td>
</tr>
<tr>
<td>• Family – In-Network and Out-of-Network combined (covering two or more individuals)</td>
<td></td>
<td>$3,000*</td>
</tr>
</tbody>
</table>

*Subject to change based on a yearly index.

All services are subject to the calendar year deductible unless otherwise specified.

<table>
<thead>
<tr>
<th><strong>Maximum Annual Out-of-Pocket Limit (Stop Loss)</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual (single coverage)</td>
<td>$3,000*</td>
<td>$6,000*</td>
</tr>
<tr>
<td>• Family (covering two or more individuals)</td>
<td>$6,000*</td>
<td>$12,000*</td>
</tr>
</tbody>
</table>

Includes the Calendar Year Deductible. In & Out-of-Network amounts remain separate—they do not cross accumulate.

*Subject to change based on a yearly index.

Annual deductibles, annual maximum out-of-pocket limits (stop loss), and annual visit limitations, will be based on a January 1 - December 31 plan year.

Member costs incurred for balance billing will not apply toward the annual deductible(s) or toward the maximum annual out-of-pocket (stop loss) limit(s).

All out-of-network providers used are subject to balance billing.
<table>
<thead>
<tr>
<th>Pre-Existing Conditions</th>
<th>PLAN PROVISIONS AND BENEFITS</th>
<th>PLAN PROVISIONS AND BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Physician Services Provided In An Office Setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Office Visit</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>• Wellness Care/Preventive Healthcare</td>
<td>100%; <em>not subject to deductible.</em></td>
<td>70%; <em>not subject to deductible.</em></td>
</tr>
</tbody>
</table>

*Physical Exam, Mammogram, Pap Smear, Prostate Exam/PSA, Well-baby Care and Immunizations, Adult Immunizations, Routine Eye Exams, Routine Hearing Exams*
<table>
<thead>
<tr>
<th>SELECTED PLAN FEATURES AND COVERED SERVICES</th>
<th>PLAN PROVISIONS AND BENEFITS In-Network</th>
<th>PLAN PROVISIONS AND BENEFITS Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Laboratory Services</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>(Exclusive of Wellness Care/Preventive Healthcare)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory, X-ray, Allergy Testing, Diagnostic Tests, and Injectable Medications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable medications that are provided in a physician’s office may be covered under medical benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-certification for diagnostic testing may be required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maternity Care</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>(Routine Prenatal care, Delivery and Postnatal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Surgery</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Pre-certification may be required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Second Surgical Opinion</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>(Elective Surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allergy Testing</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>• Allergy Shots &amp; Serum</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>SELECTED PLAN FEATURES AND COVERED SERVICES</td>
<td>PLAN PROVISIONS AND BENEFITS</td>
<td>PLAN PROVISIONS AND BENEFITS</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>• Treatment of TMJ (Temporomandibular Joint Disorders)</td>
<td><strong>In-Network</strong> 90%</td>
<td><strong>Out-of-Network</strong> 70%</td>
</tr>
<tr>
<td></td>
<td><strong>Pre-certification may be required.</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Physician Services</strong>&lt;br&gt;Physician Care/Surgery</td>
<td><strong>In-Network</strong> 90%</td>
<td><strong>Out-of-Network</strong> 70%</td>
</tr>
<tr>
<td></td>
<td>Some <em>hospital-based</em> Physicians (examples: emergency room physicians, anesthesiologists, pathologists, and/or radiologists) providing services may not be a part of the network. Services provided by <em>non-network</em> physicians will be covered at 70% of the network rate; <em>subject to the out-of-network deductible and balance billing.</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Pre-certification may be required.</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>Hospital Services</strong>&lt;br&gt;Other Than Those For Emergency Room Care</td>
<td><strong>In-Network</strong> 90%; Limited to semi-private room</td>
<td><strong>Out-of-Network</strong> 70%</td>
</tr>
<tr>
<td></td>
<td>Inpatient Care (Includes inpatient short term rehabilitation services)</td>
<td></td>
</tr>
<tr>
<td>SELECTED PLAN FEATURES AND COVERED SERVICES</td>
<td>PLAN PROVISIONS AND BENEFITS</td>
<td>PLAN PROVISIONS AND BENEFITS</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------</td>
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</tr>
<tr>
<td><img src="image1.png" alt="Image" /></td>
<td><img src="image2.png" alt="Image" /></td>
<td><img src="image3.png" alt="Image" /></td>
</tr>
</tbody>
</table>

- **Maternity Care**
  - **In-Network**: 90%
  - **Out-of-Network**: 70%

- **Laboratory Services**
  - **In-Network**: 90%
  - **Out-of-Network**: 70%

- **Hospice Care**
  - **In-Network**: 100%; subject to deductible.
  - **Out-of-Network**: 100%; subject to deductible and balance billing.

- **Treatment of TMJ**
  - **Temporomandibular Joint Disorders**
  - **Surgical treatment**
    - **Pre-certification may be required.**
  - **In-Network**: 90%
  - **Out-of-Network**: 70%

- **Outpatient Hospital/Facility Services**
  - **Physician Services**
    - **Physician Care/Surgery**
      - **Pre-certification may be required.**
      - **In-Network**: 90%
      - **Out-of-Network**: 70%

  Some *hospital-based* physicians (examples: emergency room physicians, anesthesiologists, pathologists, and/or radiologists) providing services may not be a part of the network. Services provided by *non-network* physicians will be covered at 70% of the network rate; *subject to the out-of-network deductible and balance billing.*
<table>
<thead>
<tr>
<th>SELECTED PLAN FEATURES AND COVERED SERVICES</th>
<th>PLAN PROVISIONS AND BENEFITS</th>
<th>PLAN PROVISIONS AND BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care in a Hospital Emergency Room (ER)</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td><em>For treatment of an emergency medical condition or injury</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgent Care Services</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>• Home Nursing Care</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td><em>Pre-certification may be required.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health services are limited to 120 visits per calendar year (combined in-network and out-of-network)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Extended Care Facility</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td><em>Pre-certification is required.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 30 days per member per plan year (combined in-network and out-of-network)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cochlear Implants</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td><em>Pre-certification may be required.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Wigs (when medically necessary) $500 yearly maximum</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>SELECTED PLAN FEATURES AND COVERED SERVICES</td>
<td>PLAN PROVISIONS AND BENEFITS</td>
<td>PLAN PROVISIONS AND BENEFITS</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td>• Ambulance Services</td>
<td>90%; subject to balance billing for non-participating providers of ambulance services.</td>
<td></td>
</tr>
<tr>
<td>Land or air ambulance for medically necessary emergency transportation only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Durable Medical Equipment (DME)</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Rental or Purchase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Short Term Rehabilitation Services</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers – 20 visits per calendar year combined specialties for in and out of network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy – 20 visits per calendar year in and out of network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy – 30 visits per calendar year in and out of network combined</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SELECTED PLAN FEATURES AND COVERED SERVICES

<table>
<thead>
<tr>
<th>Limited Medical Coverage for Dental/Oral Care</th>
<th>PLAN PROVISIONS AND BENEFITS</th>
<th>PLAN PROVISIONS AND BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgical Extraction of Impacted Teeth</td>
<td><strong>In-Network</strong> 90%</td>
<td><strong>Out-of-Network</strong> 70%</td>
</tr>
<tr>
<td><em>Medical benefits are not available for partially erupted teeth.</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental/Oral Care</th>
<th><strong>In-Network</strong> 90%</th>
<th><strong>Out-of-Network</strong> 70%</th>
</tr>
</thead>
</table>
| *Not covered; other than accidental injury to natural teeth.* (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 occurring while a member is covered by this contract and performed within 180 days after the accident.)

Please Note: Outpatient charges and anesthesia for dental services for children may be covered but will require prior approval.

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th><strong>In-Network</strong> 90%</th>
<th><strong>Out-of-Network</strong> 90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day supply (retail Participating pharmacy)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

If a non-participating pharmacy is used, the Member must file a claim for reimbursement; the Member may be responsible for the difference between the maximum allowed amount and the pharmacy’s actual charge.
<table>
<thead>
<tr>
<th><strong>SELECTED PLAN FEATURES AND COVERED SERVICES</strong></th>
<th><strong>PLAN PROVISIONS AND BENEFITS</strong></th>
<th><strong>PLAN PROVISIONS AND BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse</strong></td>
<td><strong>Inpatient &amp; Out-Patient</strong></td>
<td><strong>Inpatient &amp; Out-Patient</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Treatment</strong></td>
<td><strong>Treatment</strong></td>
</tr>
<tr>
<td></td>
<td>90% of network rate</td>
<td>70% of eligible charges</td>
</tr>
<tr>
<td><strong>Please contact BCBSGa to determine if pre-certification is required at the number shown on your identification card.</strong></td>
<td>** please contact BCBSGa at 1-866-694-0724.**</td>
<td></td>
</tr>
<tr>
<td><strong>Please note that Partial/Day Hospitalization &amp; Intensive Outpatient services are not covered.</strong></td>
<td><strong>The Centers of Excellence Programs direct patients to network heart, liver, lung and bone marrow transplant specialists.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prior approval may be required.</strong></td>
<td><strong>Out-of-Network: 70% of UCR at a non-contracted transplant center; subject to deductible and to balance billing.</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Organ and Tissue Transplants**

**In-Network:** 90% at a contracted transplant center; subject to deductible

**Out-of-Network:** 70% of UCR at a non-contracted transplant center; subject to deductible and to balance billing.

**There will be no donor search benefit provided if an individual uses a non-contracted transplant center.**

For additional information regarding the COE Program for organ and tissue transplants, please contact BCBSGa at 1-866-694-0724.
The University System of Georgia POS healthcare plan does not have the legal authority to intervene when a non-participating provider balance bills the member. Therefore, the healthcare plan cannot reduce or eliminate balance billed amounts. The healthcare plan will not make additional payments above the plan allowed benefit limits.
WHO CAN ENROLL

If you are employed by the University System of Georgia with a work commitment of three-quarters time (30 hours per week) or more on a regular basis, you are eligible for coverage under the POS healthcare plan. If you are a member of the Corps of Instruction (teaching faculty) under contract with a work commitment of three-quarters time (30 hours per week) or more on a regular basis, you are eligible for coverage under the POS healthcare plan.

HOW TO ENROLL

You must complete a POS health benefits plan enrollment form to apply for healthcare coverage. You may obtain this form from your campus Human Resources/Personnel Office. The completed enrollment form must include the legal names and birth dates of all eligible dependents.

The POS healthcare plans provide four levels of coverage:

<table>
<thead>
<tr>
<th>Single</th>
<th>Employee + Child</th>
<th>Employee + Spouse</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>Employee + One Dependent Child</td>
<td>Employee + Spouse</td>
<td>Employee + Two or More Dependents (Spouse and/or Children)</td>
</tr>
</tbody>
</table>

DEPENDENT COVERAGE

When an employee elects “Employee + Child”, “Employee + Spouse”, or “Family” coverage, his/her eligible dependents may be covered by the healthcare plan selected. Eligible dependents of an employee include:

- Legal spouse (does not include common law spouse);

- The Employee’s dependent children until attaining age 26, legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee’s children (or children of the Employee’s Spouse) for whom the Employee has legal responsibility resulting from a valid court decree.

- Children who are mentally or physically disabled and totally dependent on the Employee for support, regardless of age, with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan or have prior Creditable Coverage prior to reaching age 26.
Certification of the disability is required within 30 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically.

If you have a dependent(s) employed by the University System of Georgia, and your dependent(s) is participating in any University System of Georgia healthcare plan, you **may not** cover that dependent(s) under your “employee + child”, “employee + spouse”, or “family” coverage.

If your spouse is employed by the University System of Georgia, but he/she does not elect to participate in an available healthcare plan, you may cover him/her under your “employee + spouse” or “family” coverage.

*If both a husband and wife are benefits-eligible employees of the University System of Georgia, only one may elect to provide coverage for the other spouse and/or dependents.*

**WHEN EMPLOYEE COVERAGE BEGINS**

If you enroll in healthcare coverage on your first day of employment, you will be covered by the plan as of:

- Benefits become effective on the first day of the month following enrollment unless enrollment is on the first day of the month in which case it becomes effective upon enrollment. For those employees covered under an academic contract, benefits will begin on the first day of the contract if enrolled on or before that day or on the first day of the month following enrollment if they enroll after the contract start.

As an employee of the University System of Georgia, you have 30 days from your effective date of employment to enroll for coverage in a healthcare plan. If you enroll in a healthcare plan within 30 days of your employment date, you will be covered by the plan as of:

- Benefits become effective on the first day of the month following enrollment unless enrollment is on the first day of the month in which case it becomes effective upon enrollment. For those employees covered under an academic contract, benefits will begin on the first day of the contract if enrolled on or before that day or on the first day of the month following enrollment if they enroll after the contract start.

**WHEN DEPENDENT COVERAGE BEGINS**

An eligible dependent will become covered on:

- The first day that he/she becomes eligible; or
- The first of the month following his/her date of eligibility.
You will be required to ensure that your dependents, including newborns, are enrolled under your plan coverage within 30 days following his/her eligibility date. You should contact your campus Human Resources/Personnel Office to convey all appropriate information.

An eligible newborn is covered at birth. A dependent, other than a newborn, who is confined to a hospital or other institution when his/her coverage would normally begin, will be covered upon his/her discharge.

If you enroll your dependents within 30 days following their eligibility date, their coverage will begin on:

- The date you apply for coverage; or
- The first of the month following the date in which you apply for coverage.

You will have the opportunity to determine when you wish to have your dependent’s coverage begin; but, in either instance, you will be required to pay for a full month of coverage. It is important that you enroll your dependents within 30 days of their becoming eligible for coverage. You will not be permitted to enroll your dependents in an available healthcare plan again until the next University System of Georgia open enrollment period.

**ADDING OR DELETING DEPENDENTS**

When you have a qualifying event, you will need to contact your campus Human Resources/Personnel Office to complete a change form to add or to delete a dependent. Some examples of “qualifying events” include: (A) a change in employment status for you or your spouse; (B) a change in marital status; and (C) the birth or adoption of a child (including stepchildren and legally placed foster children). *There are other examples of qualifying events.* Change forms must be completed with your campus Human Resources/Personnel Office within 30 days of a qualifying event. Failure to comply with this time requirement will prohibit you from changing your coverage until the next University System of Georgia open enrollment period.

**Change of Status Upon Attainment of Age 26**

Your POS healthcare plan will provide coverage for your dependent until he/she attains age 26. *On a dependent’s 26th birthday*, his/her healthcare coverage will terminate. For information regarding your dependent’s ability to continue healthcare coverage, please see page 73 for the section entitled, *Your COBRA Rights.*

**USG OPEN ENROLLMENT PERIOD**

Open enrollment is generally held during the fall of each calendar year. A University System of Georgia open enrollment period covers a 30 calendar-day time frame. Your Human Resources/Personnel Office will advise you of the specific dates for your campus open enrollment period.
Healthcare plan elections made during an open enrollment period will become effective at the beginning of a new plan year. The plan year for the University System of Georgia is currently a calendar year (January 1 – December 31).

During an open enrollment period, an active and eligible employee may elect to: (1) enroll in a healthcare plan; (2) drop healthcare coverage; (3) participate in a different healthcare plan option; and/or (4) change his/her level of coverage (i.e. single, employee + child, employee + spouse, or family). Members who have COBRA coverage will have the same open enrollment period and options.

THE COST OF YOUR HEALTHCARE COVERAGE

The University System of Georgia contributes a majority of the cost associated with your health benefits plan coverage. Information regarding employer/employee healthcare plan contribution rates is shared with your campus Human Resources/Personnel Office. The costs associated with providing various healthcare plan options to employees, retirees and dependents of the University System of Georgia changes periodically. Your campus Human Resources/Personnel Office will notify you of any changes in plan costs and in employer/employee contribution rates. Your premium will depend upon the level of coverage (single, employee + child, employee + spouse, or family) that you select. The healthcare plan premium contribution for active, eligible employees will be paid with pre-tax dollars.

QUALIFYING EVENTS FOR CHANGES IN HEALTHCARE PLAN COVERAGE

Because your share of the cost for healthcare plan premiums is paid with pre-tax dollars, the Internal Revenue Services (IRS) has established strict rules regarding the operation of your healthcare plan. IRS rules state that the choices made by a covered member during an annual open enrollment period must remain in effect for the entire plan year (January 1 through December 31). The only exception permitted under IRS rules is when a covered member has a qualifying event.

If you have a qualifying event, you may add, change, or discontinue healthcare coverage. Appropriate documentation, specific to the qualifying event, must be presented to your campus Human Resources/Personnel Office before a change in healthcare plan coverage will be granted or approved. Some examples of qualifying events include:

- A change in your marital status;
- The birth or adoption of a child (including stepchildren and legally placed foster children);
- The death of a covered dependent;
• A change in the employment status of a covered member, his/her spouse, or his/her covered dependent(s), that affects eligibility for coverage under a cafeteria or other qualified healthcare plan;

• The loss of eligibility status by a covered dependent;

• A campus approved leave of absence without pay (maximum of 12 months);

• You and/or your spouse being called to full-time active military service/duty;

• Losing or gaining healthcare coverage eligibility under Medicare or Medicaid;

• A change in residence to a location outside of a healthcare plan’s service area;

• Healthcare plan election choices made by spouses with different employers in which the employers have a different healthcare plan years (*Please see the example below*); or

**Example:**

You work for the University System of Georgia (USG) and have a January 1 – December 31 health benefits plan year. Your spouse works for XYZ employer. XYZ has an October 1 – September 30 health benefits plan year. Both employer health benefits plans are qualified healthcare plans.

You have “single” healthcare coverage with the University System of Georgia. Your spouse, employed by XYZ, discontinues his/her healthcare coverage with XYZ effective September 30. September 30 is the end of employer XYZ’s plan year. You wish to add your spouse, employed by XYZ, under your healthcare plan with the University System of Georgia, effective October 1. You request to make this change to avoid a break in healthcare coverage for your spouse.

Your spouse, employed by XYZ, conveys to XYZ that he/she will no longer participate in XYZ’s healthcare plan effective October 1. Under IRS regulations, the University System of Georgia may permit you to change your election from “single” to “employee + spouse” effective October 1. The spouse, employed by XYZ, must provide documentation/certification to the USG that he/she has lost healthcare coverage with XYZ.

**Qualified Medical Child Support Order (QMCSO)**

A court-ordered qualified medical child support order (QMCSO) results from a divorce, legal separation, annulment, or change in legal custody. A QMCSO will require that you, your spouse, former spouse or other individual provide healthcare coverage for those enrolled dependent(s) that have been approved by the court. The court order and the effective date of healthcare plan coverage for those court-designated enrolled dependent(s) must be presented to your Human Resources/Personnel Office within 90 days of the court’s decision.
**PLEASE NOTE:**

For each of the qualifying events identified above, you must file a *timely* request with your Human Resources/Personnel Office to add or to change healthcare coverage. For instances other than a qualified medical child support order (QMCSO), “*timely*” means *within 30 days of the event* that qualified you for a change in healthcare coverage (i.e., employment, loss of coverage, marriage, birth or adoption, etc.) A QMCSO must be presented to your Human Resources/Personnel Office within 90 days of a court’s decision.

A failure to complete a change form within 30 days of a qualifying event will prohibit you from making such changes until the next University System open enrollment period. Unless otherwise noted, the effective date for changes in healthcare coverage will be the first day of the month following institutional approval.

**CONTINUATION OF HEALTHCARE COVERAGE INTO RETIREMENT**

A University System of Georgia retiree, who, upon his/her separation from employment with the University System of Georgia, meets the criteria for retirement as set forth in Section 802.0902 (Definition of a Retiree/Eligibility for Retirement) of *The Policy Manual*, shall remain eligible to continue as a member of one of the System’s group health benefits plans. The level of healthcare coverage that one may take into retirement will be the level of coverage that he/she had immediately prior to retirement.

**USG RETIREE ANNUAL CHANGE PERIOD**

The USG retiree annual change period is generally held during the fall of each calendar year. The USG retiree annual change period will coincide with the same 30 calendar-day time frame designated as the USG open enrollment period for active, eligible employees. The institutional Human Resources/Personnel Office, from which an individual retires, will advise the retiree of the specific dates for his/her annual change period.

*A retiree will not be permitted to participate in the annual change period unless he/she elected to take healthcare coverage into retirement at the time of his/her separation from employment with the University System of Georgia.*

During an annual retiree change period, an eligible retired employee may elect to: (1) drop or discontinue healthcare coverage; (2) participate in a different healthcare plan option; and/or (3) reduce his/her level of coverage. During the annual change period, a retiree shall not be permitted to add healthcare coverage, or, increase the level of coverage that he/she took into retirement, *unless it is the result of one of four (4) qualifying events*.

Following institutional approval, any change in retiree healthcare coverage will become effective within 30 days of the qualifying event; *not at the beginning of the next plan year.*
QUALIFYING EVENTS FOR CHANGES IN RETIREE HEALTHCARE PLAN COVERAGE

A USG retiree will be permitted to make a change in the level of healthcare coverage that he/she took into retirement, if he/she has a qualifying event. The change in retiree healthcare coverage must be consistent with the qualifying event. A retiree will be required to provide the proper documentation to justify a requested benefits coverage change to the institutional Human Resources/Personnel Office from which he/she retired. A retiree must request a coverage change within 30 days of the qualifying event.

Appropriate documentation, specific to the qualifying event, must be presented to your campus Human Resources/Personnel Office before a change in healthcare plan coverage will be granted or approved.

There will be only four (4) instances of a qualifying event that a University System of Georgia institution may consider in granting a change in the level of healthcare coverage for a USG retiree. They are:

1. Becoming eligible for Medicare;
2. The addition of a dependent(s) because of marriage, birth, adoption or a Qualified Medical Child Support Order (QMSCO);
3. The loss of a dependent’s health benefit coverage through a change in a spouse’s group coverage, through COBRA coverage, through Medicare, or through Medicaid; and
4. A change in a spouse’s employment status that affects coverage eligibility under a qualified health plan.

A Qualified Medical Child Support Order (QMSCO) is a court-ordered remedy resulting from a divorce, legal separation, annulment, or change in legal custody. A QMSCO requires that an individual provide healthcare coverage for an enrolled dependent(s) that has been approved by the court. The court order and effective date of healthcare plan coverage for a court-designated enrolled dependent(s) must be presented to the institutional Human Resources/Personnel Office from which an individual retired, within 90 days of the court’s decision.

PLEASE NOTE:

For each of the four (4) qualifying events that are identified above, one must file a timely request with the Human Resources/Personnel Office from which he/she retired. For instances other than a qualified medical child support order (QMSCO), “timely” means within 30 days of the qualifying event. A QMSCO must be presented to the appropriate Human Resources/Personnel Office within 90 days of the court’s decision.

A failure to complete a change form within 30 days of a qualifying event will prohibit one from making such changes. Unless otherwise noted, the effective date for changes in healthcare coverage will be the first day of the month following the institution’s approval.
PERMISSIBLE USG RETIREE HEALTHCARE PLAN CHANGES

Please be reminded that retiree healthcare premiums are not paid with pre-tax dollars. Therefore, a retiree may reduce his/her healthcare coverage, or, discontinue his/her healthcare coverage at any time during the plan year. If you wish to reduce your healthcare coverage, or, if you wish to discontinue your healthcare coverage, please submit your request in writing to the Human Resource/Personnel Office from which you retired.

Please be reminded that if you reduce your level of healthcare coverage, you will not be permitted to increase your coverage at a later date, without establishing one of the four (4) qualifying events previously identified. As a retiree, if you elect to discontinue your healthcare coverage, you will not be permitted to re-enroll at a later date.
THE ANNUAL DEDUCTIBLE

The annual deductible is an amount of money that you will be required to pay each plan year (January 1 – December 31) for covered benefit expenses, before the plan will begin to pay for its portion of covered charges. Your annual healthcare plan deductibles are as follows:

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Maximum Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual – In-Network and Out-of-Network combined (single coverage)</td>
<td>$1,500*</td>
<td></td>
</tr>
<tr>
<td>• Family – In-Network and Out-of-Network combined (covering two or more individuals)</td>
<td>$3,000*</td>
<td></td>
</tr>
</tbody>
</table>

*Subject to change based on a yearly index.

Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).
THE MAXIMUM ANNUAL OUT-OF-POCKET LIMIT
(Stop Loss)

The POS healthcare plan provides for a member’s protection if his/her out-of-pocket covered expenses reach a certain limit during a plan year.

For a member who uses an In-Network provider, the annual out-of-pocket limit is $3,000 for individual coverage and $6,000 for family coverage. For a member who uses an Out-of-Network provider, the annual out-of-pocket limit is $6,000 for individual coverage and $12,000 for family coverage.

Your POS maximum annual out-of-pocket limit (stop loss) will be:

<table>
<thead>
<tr>
<th>Maximum Annual Out-of-Pocket (Stop Loss)</th>
<th>Plan Provisions and Benefits</th>
<th>Plan Provisions and Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
</tr>
<tr>
<td><strong>Maximum Annual Out-of-Pocket Limit (Stop Loss)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual (single coverage)</td>
<td>$3,000*</td>
<td>$6,000*</td>
</tr>
<tr>
<td>• Family (covering two or more individuals)</td>
<td>$6,000*</td>
<td>$12,000*</td>
</tr>
</tbody>
</table>

Includes the Calendar Year Deductible. In & Out-of-Network amounts remain separate—they do not cross accumulate.

*Subject to change based on a yearly index.
ADMINISTRATIVE AGENTS/BUSINESS ASSOCIATES

The current administrative agents/business associates for the University System of Georgia POS healthcare plans include:

WellPoint/Blue Cross Blue Shield of Georgia
- Provides customer service; and
- Provides claims administration services.
- Provides pre-certification for specific outpatient and all inpatient hospital services;
- Provides case management services;
- Provides access and education regarding 360° Health Programs;
- Provides access to organ and tissue transplant network Centers of Excellence;
- Provides access to 24/7 NurseLine
- Provides the network of hospitals, facilities and medical providers within Georgia, Nationally and Internationally
- Provides behavioral health and substance abuse services.
- Provides pharmacy management services

HOW YOUR BENEFITS WORK FOR YOU

Introduction
The Point of Service (POS) Plan is a comprehensive network of healthcare providers and facilities that have signed direct contracts with a medical network. The comprehensive medical network provides treatment and services at discounted rates. These network contracts help reduce your out-of-pocket medical expenses for in-network physicians, hospitals and ancillary services. “Ancillary services” would include those medical services such as physical therapy, laboratory work, and home healthcare.

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.

Calendar Year Deductible
Before your program begins to pay benefits you must meet any Deductible required. Deductible requirements are stated in the Summary of Benefits.
Coinsurance and Out-of-Pocket Limit

The percentage payable by BCBSGA is stated in the Summary of Benefits. The portion which you must pay (the Coinsurance) is stated in the Summary of Benefits. After you reach your Out-of-Pocket Limit, your Contract pays 100% of Covered Services for the remainder of the calendar year.

See the Summary of Benefits to determine if you have a Coinsurance Amount and an Out-of-Pocket Limit.

What Your Plan Pays

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 for this plan is the maximum amount of reimbursement the Claims Administrator will pay for services and supplies:

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

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-network or Non-Preferred Provider either in an emergency or when services have been previously authorized, 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 100% for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

**PROVIDER NETWORK STATUS**
The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network or 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 the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for that service, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [www.bcbsga.com](http://www.bcbsga.com).

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

For Covered Services you receive in an emergency or if previously authorized from an Out-of-network Provider, the Maximum Allowed Amount for this plan will be one of the following as determined by the Claims Administrator:

1. An amount based on our Out-of-network fee schedule/rate, which we have established in 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 the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers’ fees and costs to deliver care, or

4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the
Maximum Allowed Amount calculated by using one of the methods described above.

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

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

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

Participant 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 Summary of Benefits section in this Benefit Booklet for your cost share responsibilities and
limitations, or call Customer Service to learn how this plan’s benefits or cost share amounts may vary by
the type of Provider you use.

The Claims Administrator 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, your Lifetime Maximum, benefit caps or day/visit limits.

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

Example: Your plan has a Coinsurance cost share of 20% for In-Network services, and 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 us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Covered Service so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider’s charge. Please contact Customer Service for Authorized Services information or to request authorization.
Example:
You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your plan has a $45 Copayment for Out-of-Network Providers and a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider’s charge for this service is $500 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 Claims Administrator will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

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

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

**Hospital Pre-certification**

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

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

**In-Network Care**
- If you are hospitalized other than in an emergency and Pre-Admission Certification was not obtained, all charges will be denied. You will be held harmless if all network guidelines are followed and you were admitted to a Preferred or Participating Hospital. This means you will not be responsible for any bill in excess of the related Deductible, Coinsurance that applies, and Non-Covered Services.
If your stay exceeds the number of days assigned under this program, the Hospital’s charge for additional days beyond the assigned length of stay will not be paid. If all In-Network guidelines are followed, you will not be responsible for any Covered Services except the normal Deductible, Coinsurance and Non-Covered Services.

- Charges for Ineligible Charges and Non-Covered Services are always the Member’s responsibility.
- PAC is the responsibility of the Preferred Hospital or Preferred Physician.

**Out-of-Network Care**

- You, the Physician or the Hospital **must** obtain approval for all Hospital admissions.
- If you are hospitalized other than in an emergency and Pre-Admission Certification was not obtained, there will be a $500 penalty applied before payment can be made. You will be responsible for this $500 in addition to any related Deductible, Coinsurance, charges above UCR Fees 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 a Preferred or Non-Preferred Hospital and the admission is determined not to be Medically Necessary, all charges for that admission and related Physician charges will be Ineligible Charges. Out-of-Network Providers are under no obligation to hold you harmless for those charges, so you may be responsible for the full amount of all of those charges.

Ineligible Charges are always the Member’s responsibility.

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

**Outpatient Pre-certification Requirements**

**Outpatient pre-certification is a requirement for Network benefits.**

Your Contract provides Covered Services when outpatient services are Medically Necessary. Certain outpatient procedures require pre-certification. This outpatient pre-certification is a requirement for both In-network and Out-of-network benefits if applicable.

Such services include, but are not limited to:

- Arthroscopy – shoulder & knee
- Biofeedback
- CT Scans (Computed Tomography Scan)
- CTA
- Echocardiography (if not ordered by a Cardiologist)
- Home Health Care
• Nuclear Cardiology
• Stress Thallium (if not ordered by a Cardiologist)
• Hysterectomy (under age 35)
• MRI and MRA
• Orthognathic/TMJ
• PET Scans
• Reconstructive Surgery
• Sleep Studies
• UPPP

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.

Preferred / In-Network and Participating Provider
• If you receive treatment and pre-certification was not obtained, or the treatment is determined not to be Medically Necessary, all charges will be Ineligible Charges. You (the Member) will be held harmless if all In-Network guidelines are followed and services are performed by a Preferred or Participating Provider. This means you will not be responsible for any bill in excess of the related Coinsurance and/or Deductible amounts.
• Ineligible Charges and Non-Covered services are always the Member’s responsibility.
• Pre-certification is the responsibility of the Preferred or Participating Physician.

Non-Preferred / Out-of-Network or Non-Participating Provider
• You (the Member) or the Physician must obtain approval for all procedures listed above.
• If you receive treatment and pre-certification was not obtained, a $500 penalty will be applied before payment is made. You (the Member) will be responsible for this $500 in addition to any related Deductible and Coinsurance, charges above UCR Fees and Non-Covered Services which may apply.
• If you receive treatment and the procedure is determined not to be Medically Necessary, all charges for that procedure 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.
BENEFITS

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

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

Ambulance Service
Local service to 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 to the nearest appropriate facility is covered subject to Medical Necessity.

Anesthesia Services for Certain Dental Patients
General anesthesia and associated Hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:
- Patients age 7 or younger or developmentally disabled.
- An individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder.
- An individual who has sustained extensive facial or dental trauma, except for a Workers’ Compensation claim.

Pre-certification is required.

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

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

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

Cardiac Rehabilitation
Programs require Pre-certification and Individual Case Management.
**Colorectal Cancer Examinations and Laboratory Tests**
Covered Services include colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening. Benefits shall be provided for Members who are 50 years of age or older and less than 50 years of age and at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society.

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

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

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

**Diabetes**
Equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes 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.

**Dialysis Treatment**
Dialysis treatment is covered if care when pre-certification approval has been obtained from BCBSGA.

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

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

Emergency Room Care
Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for a Medical Emergency or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or cause serious harm.

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 Summary of Benefits. A visit consists of up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member’s attending Physician. Services may be performed by either Preferred or Non-Preferred Providers.
Some special conditions apply:
• The Physician’s statement and recommended program must be pre-certified.
• Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis.
• A Member must be essentially confined at home.

Covered Services:
1. Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
2. Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Contract.
3. 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.
4. Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
5. Nutritional guidance when Medically Necessary.
6. Administration of prescribed drugs.
7. Oxygen and its administration.

**Covered Services for Home Health Care do not include:**
1. Food, housing, homemaker services, sitters, home-delivered meals;
2. Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
3. Services and/or supplies which are not included in the Home Health Care plan as described.
4. Services of a person who ordinarily resides in the patient’s home or is a member of the family of either the patient or patient’s spouse.
5. Any services for any period during which the Member is not under the continuing care of a Physician.
6. Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient.
7. Any services or supplies not specifically listed as Covered Services.
8. Routine care and/or examination of a newborn child.
9. Dietitian services.
10. Maintenance therapy.
12. Purchase or rental of dialysis equipment.
13. Private duty nursing care.

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

Your Contract provides Covered Services for Inpatient and outpatient Hospice care as stated in the **Summary of Benefits**. The Hospice treatment program must:
- Be recognized as an approved Hospice program by BCBSGA;
- Include support services to help covered family members deal with the patient’s death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
  - provides an organized system of home care;
  - uses a Hospice team; and
  - has around-the-clock care available.

To qualify for Hospice care, the attending Physician must certify that the patient is not expected to live more than six months. Also, the Physician must design and recommend a Hospice Care Program. The Physician’s statement and recommended program must be pre-authorized.
Hospital Services
You may receive treatment at a Preferred or Non-Preferred Hospital. However, payment is significantly reduced if services are received at a Non-Preferred Hospital. Your Contract provides Covered Services when the following services are Medically Necessary.

Preferred

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

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

Length of Stay
- Determined by Medical Necessity.

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

Non-Preferred

Inpatient / Outpatient Hospital Benefits
- If you are confined in a Non-Preferred Hospital or receive covered outpatient services, your benefits will be significantly reduced, as explained in the “How Your Benefits Work For You” section. Pre-certification is required for all Hospital admissions and certain outpatient procedures.

Hospital Visits
The Physician’s visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each Physician during the covered period of confinement.
**Individual Case Management**

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

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

**Eligibility**

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

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

The Member—or legal guardian or family member, if applicable—and the attending Physician must consent to explore with BCBSGA 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 applicable Contract.

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

Benefits under the program are furnished as an alternative to other Contract benefits and are limited to the following:
- Services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Member.
- Non-structural modifications to the home which are required to meet minimum standards for safe operation of equipment.
- When necessary for the long term care of the Member in the home-setting, Respite Care to relieve family members or other persons caring for the Member at home. (The Respite Care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. BCBSGA 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 BCBSGA regarding the treatment plan and proposed setting to be utilized during the Respite Care period.

Potential cases include but are not limited to:
- spinal cord Injury;
- severe head trauma/coma;
- respiratory dependence;
- degenerative muscular/neurological disorders;
- long term IV antibiotics;
- premature birth;
- burns;
- cardiovascular accident;
- cancer;
- accidents;
- terminal illnesses;
- other cases at BCBSGA’s discretion.

**Covered Services**
- Services covered under individual case management will be determined by BCBSGA, 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 its sole discretion, in the context of an individual case management program, BCBSGA 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 BCBSGA 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 paid under this program will not exceed those which the Member would otherwise have received in the absence of individual case management benefits.

**Exclusions**
- Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in BCBSGA’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 BCBSGA to manage and coordinate the Member’s medical benefits under the individual case management program. The Case Manager’s role is determined by BCBSGA.

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

**Termination of Individual Case Management**
Services in the alternative benefit plan approved by the Claims Administrator under individual case management will cease to be Covered Services under this Plan when extra-contractual benefits or alternative services are no longer Medically Necessary, as determined by the Plan Sponsor, due to a change in the patient’s condition.

**Licensed Speech Therapist Services**
The visits must be pre-certified by BCBSGA. 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 specified functional deficits identified.

**Licensed Clinical Social Worker**
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.

**Licensed Mid-Level Providers**
Benefits are also payable for Covered Services provided by licensed mid-level providers. Such providers include, but are not limited to, Nurse Practitioners (NP), Physician Assistant (PA), and Physician Assistant Anesthetists (PAA).

**Maternity Care**
Covered Services are provided for In-Network Maternity Care as stated in the Summary of Benefits.

Maternity benefits are provided for a female Employee and any eligible female Dependent.

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

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See “Changing Your Coverage” to add a newborn to your coverage.)
Under federal law, the Contract may not restrict the length of stay to less than the 48/96-hour periods or require pre-certification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member’s attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48- or 96-hour period. These visits may be provided either in the Physician’s office or in the Member’s home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member’s attending Physician.

Benefits are also payable for prenatal care, delivery services and postnatal care rendered by a Certified Nurse Midwife (CNM).

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

**Non-Contracted Freestanding Ambulatory Facility**
Any services rendered or supplies provided while you are a patient or receive services at or from a Non-Contracted Freestanding Ambulatory Facility will be payable at the default reimbursement rate.

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

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

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

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

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

**Organ/Tissue/Bone Marrow Transplant**

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

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

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

A covered transplant means a Medically Necessary transplant of one of the following organs or tissues only and no others.

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

“Donor Costs” means all costs, direct and indirect (including program administration costs), incurred in connection with:
• medical services required to remove the organ or tissue from either the donor’s or the self-donor’s body;
• preserving it; and
• transporting it to the site where the transplant is performed.

In 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 the Contract.

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

“Medically Necessary” means the recipient or self-donor meets the criteria for a transplant established by BCBSGA.

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

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

**Pre-certification Requirement**
All transplant procedures must be pre-certified for type of transplant and be medically appropriate according to criteria established by BCBSGA. To pre-certify, call the BCBSGA office using the telephone number on your Identification Card.

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

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

- If a Member receives a transplant and the donor is also covered under this Contract, payment for the Member and the donor will be made under each individual’s coverage.
- If the donor is not covered under this Contract, payment for the Member and the donor will be made under this Contract but will be limited by any payment which might be made under any other hospitalization coverage plan.
- If the Member is the donor and the recipient is not covered under this Contract, payment for the Member will be made under this Contract limited by any payment which might be made by the recipient’s hospitalization coverage with another company. No payment will be made under this Contract for the recipient.

Please see the “Limitations and Exclusions” section for Non-Covered Services.

**Osteoporosis**

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

**Other Covered Services**

Your Contract Provides Covered Services when the following services are Medically Necessary:

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

**Outpatient Surgery**

Preferred Hospital outpatient department or Preferred Freestanding Ambulatory Facility charges are covered at regular Contract benefits. These benefits are subject to both the Deductible and percentage payable requirements. Benefits for treatment by a Non-Preferred Hospital are explained under “Hospital Services”.

**Ovarian Cancer Surveillance Tests**

- Covered Services are provided for at risk women 35 years of age and older. At risk women are defined as: (a) having a family history (i) with one or more first or second-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, (iii) of nonpolysis colorectal cancer; or (b) testing positive for BRCA1 or BRCA2 mutations.
- Surveillance tests means annual screening using: (a) CA-125 serum tumor marker testing, (b) transvaginal ultrasound, and (c) pelvic examinations.
Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers
Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), licensed chiropractor (D.C.), or qualified athletic trainers, limited to a combined total maximum visits per calendar year as outlined in the Summary of Benefits. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

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

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

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

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

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High Blood Pressure;
   - Type 2 Diabetes Mellitus;
   - Cholesterol;
   - Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.
You may call Customer Service using the number on your ID card for additional information about these services. Information is also available at these federal government web sites:

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

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

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

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

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

**Pulmonary Rehabilitation**
Programs require prior authorization and Individual Case Management.

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

Reconstructive surgery is covered only to the extent Medically Necessary:

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

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

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

Skilled Convalescent Care during a period of recovery is characterized by:
- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the patient’s residence.

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

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

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

**Telemedicine**

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

The use of standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof does not constitute telemedicine service and is not a covered benefit.
The use of telemedicine may substitute for a face-to-face “hands on” encounter for consultation.

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

The amount of payment for the professional service provided via telemedicine by the physician or practitioner at the distant site is based on the current Covered Services for the service provided. The patient (member) is subject to the applicable deductible and co-insurance based upon their in-network or out-of-network benefits.

MENTAL HEALTH CARE and SUBSTANCE ABUSE TREATMENT

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

Professional Outpatient Care
Benefits for outpatient charges are subject to the calendar year Deductible and percentage payable provisions stated in the Summary of Benefits. Covered Services include:
- Professional care in the outpatient department of a Hospital;
- Physician’s office visits; and
- Services within the lawful scope of practice of a licensed, approved provider.

Note: To be reimbursable, care must be given by a psychiatrist, a licensed clinical psychologist, neuropsychologist, or a mid-level provider such as a Licensed Clinical Social Worker, Mental Health Clinical Nurse Specialist, a licensed Marriage and Family Therapist, or a Licensed Professional Counselor.

PRESCRIPTION DRUG PROGRAM

Benefits
The Prescription Drug Program provides coverage for drugs which, under federal law, may only be dispensed with a prescription written by a Physician. Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug Program when accompanied by a prescription. Injectable insulin is also covered even though sold without a prescription.

At the time the prescription is dispensed, present your Identification Card at the participating pharmacy. The participating pharmacist will complete and submit the claim for you. If you do not go to a participating pharmacy, you will need to submit the itemized bill to be processed.
Under the Prescription Drug Program, a 30-day supply may be dispensed for the amount determined by your benefit plan. Drug quantities exceeding FDA safety standards will be limited to those recommendations. Covered prescription inhalants will not be subject to a day limit.

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

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

**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
- 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.

**Voluntary Half-Tablet Program**
The Half-Tablet Program will allow members to pay a less instances of coinsurance on selected “once daily dosage” medications. The Half-Tablet Program allows a member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the physician to take “½ tablet daily” of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the member’s decision to participate should follow consultation with and the concurrence of his/her physician. To obtain a list of the products available on this program contact 800-441-CARE.

**Specialty Pharmacy**
Specialty Pharmacy are typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Specialty Drugs require preauthorization to be considered Medically Necessary. You may obtain the list of Specialty Drugs by contacting customer service or online at www.bcbsga.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 coinsurance may be prorated to support the method of distribution and treatment. If a Network Provider charges an administration fee for Specialty Drugs, that amount would be separate from the cost of the mail order shipment(s).

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 is subject to change.

**The following are not Covered Services under this Contract:**

- Prescription Drug products for any amount dispensed which exceed the FDA clinically recommended dosing schedule.
- Prescription Drugs received through an Internet pharmacy provider
- Non-Legend Vitamins.
- Smoking cessation products (including the use of Wellbutrin SR for this purpose).
- Over-the-counter items.
- Cosmetic Drugs (e.g., 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 pre-certification).
- The administration or injection of any Prescription Drug or any drugs or medicines.
- Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued.
- Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order.
- Prescription Drugs for which there is no charge.
- Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use.
- Prescription Drugs for use as an Inpatient or outpatient in a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients.
- Charges for delivery of any Prescription Drugs.
- Drugs and medicines which do not require a prescription order and which are not Prescription Drugs.
- Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs.
- Prescription Drugs which are not Medically Necessary or which BCBSGA determines are not consistent with the diagnosis.
- Prescription Drugs which BCBSGA determines are not provided in accordance with accepted professional medical standards in the United States.
- Any services or supplies which are not specifically listed as covered under this Prescription Drug program.
• Prescription Drugs which are Experimental or Investigational in nature as explained in the “Limitations and Exclusions” section.
• Vaccines delivered by nasal spray or mist.
• Prescription medicine for nail fungus except for immunocompromised or diabetic patients.

NEWBORN’S AND MOTHER’S HEALTH PROTECTION ACT OF 1996

Congress has passed the Newborns’ and Mothers’ Health Protection Act of 1996. This federal statute created a minimum length of inpatient hospital care that must be provided for mothers and newborns having healthcare coverage under a group or individual healthcare plan. The respective University System of Georgia healthcare plans comply with this federal mandate.

The minimum length of inpatient care will vary depending upon the medical condition of the mother. The minimum length of stay following a normal vaginal delivery is 48 hours and the minimum length of stay following a cesarean section is 96 hours. If the attending physician, in consultation with the mother, decides to discharge the mother and/or newborn prior to the mandated minimum stay, the hospital confinement requirements will not apply.

WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

Congress has passed the Women’s Health and Cancer Rights Act of 1998. This federal statute requires that group health insurance plans provide its participants with certain benefits for reconstructive surgery and/or complications related to a mastectomy. The respective University System of Georgia healthcare plans comply with this federal mandate.

The federal statute requires that a group healthcare plan provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The attending physician and the patient will discuss an appropriate medical treatment plan that may be shared with BCBSGa. The recommended treatment plan may be reviewed and approved by BCBSGa. Benefits coverage will be subject to the same deductible and coinsurance provisions that apply to the other medical and/or surgical benefits of this healthcare plan.

360° HEALTH PROGRAMS

Through the seamless total management approach of our 360° Health programs, we offer our members programs and services that have a wide-ranging suite of preventive care, wellness information, lifestyle behavior management, condition management programs and complex care support – all designed to deliver the right services to the right members at the right time.
ConditionCare programs that BCBSGa is offering to BOR POS Members are:

- Asthma: (Adult & Pediatric)
- Diabetes: (Adult & Pediatric)
- Heart Failure:
- Coronary Artery Disease:
- Chronic Obstructive Pulmonary Disorder:

BCBSGa is also offering a customized MyHealth Coach program that will address cancer, hypertension, hyperlipidemia, musculoskeletal conditions and low back pain.

Program Descriptions

Below are brief descriptions of the programs. In addition, our nurses are trained to handle all conditions including any existing co-morbidities. BCBSGa’s holistic approach to member care achieves better outcomes by focusing on the member's overall health and addresses all conditions and co-morbidities as they relate to and affect the member's ability to manage their overall health.

Asthma (adult and pediatric)
BCBSGa’s program for asthma assigns primary nurse care managers to work closely with those members identified as requiring ongoing one-on-one management and education. This strategy helps to minimize risk and improve outcomes by developing effective self-management regimens that include asthma trigger avoidance and medication compliance.

Diabetes (adult and pediatric)
Diabetes management is complicated and often overwhelming. BCBSGa’s nurse care managers and supporting health professionals, including certified diabetic counselors, collaborate to help members avoid health complications through effective lifestyle changes. BCBSGa’s program helps members follow their treating physician’s plan of care, undergo regular blood testing and screenings and observe a healthier diet. Registered dieticians, as well as other support staff also help in supporting the management of the member’s conditions and co-morbidities.

Additionally, BCBSGa supports providers with diabetic education and nutritional counseling information available through the ConditionCare programs. BCBSGa also encourages providers to refer members to the ConditionCare programs where members have access to BCBSGa dietitians for nutritional counseling and nurse care managers for additional diabetic education.

Heart Failure (HF) and Coronary Artery Disease (CAD)
Adherence to the treating physician’s plan of care for prescribed medications, diet and exercise can help members with heart failure (HF) and/or coronary artery disease (CAD) avoid the need for costly emergency room visits and hospital admissions. Through helpful condition-specific education, BCBSGa’s programs are designed to help members become better self-managers of their condition and live fuller lives. Members in any of BCBSGa’s ConditionCare programs have 24-hour toll-free access to experienced nurse care managers for questions about their condition and its management.

Chronic Obstructive Pulmonary Disease (COPD)
Chronic Obstructive Pulmonary Disease (COPD) often becomes more serious the longer a person has the condition. But with BCBSGa’s targeted COPD program, the condition’s advance can be slowed so that members can live a more normal and healthier life. For those members who are stable and controlled, the program gives members access to a staff of experienced registered nurses who are
available through a convenient toll-free phone number to answer questions about how best to live more fully with COPD. BCBSGa also has licensed pharmacists on staff to counsel members about how to take their physician-prescribed medications for maximum effectiveness.

An assigned nurse care manager provides ongoing telephonic management and education to members requiring higher intensities of targeted care for their COPD. This nurse calls on a regular basis to help ensure appropriate management of the member’s condition. BCBSGa’s nurse care managers also help members to understand the treating physician’s plan of care and collaborate as necessary with program pharmacists and dietitians to help achieve designated health goals.

MyHealth Coach
BCBSGa’s Health Advocacy program, called MyHealth Coach, targets the top tier of health care users. MyHealth Coach nurses serve as a central point of contact for individuals who have questions about a health care related topic, condition or concern, a question about benefits, a concern about claim payment or language in an 'Explanation of Benefits' statement.

BCBSGa nurses follow the member through their inpatient admission with pre-admission counseling and clinical education that follows a member through medically appropriate intervention points specific to the severity of the member’s condition and treatment plan. Additionally, MyHealth Coaches perform post-discharge planning which may require arranging for services like outpatient rehabilitation or home health care. MyHealth Coaches also reach out to members before and after hospitalizations to ensure members are prepared both before they go in for a procedure and once they are discharged.

MyHealth coaches can also find the appropriate providers for the member. Additionally, if the MyHealth Coach RN finds that the member would be more appropriately managed through one of BCBSGa’s ConditionCare or transplant programs, the MyHealth Coach program refers the member to the appropriate nurse care manager.

The program offered for BOR members can provide guidance for a wide array of conditions too numerous to list, but will have targeted identification for the following health conditions:

- **Hypertension** – Vascular-related conditions like Hypertension are often associated with an increased risk for other chronic conditions like coronary artery disease (CAD), diabetes, stroke, peripheral vascular disease and peripheral artery disease. MyHealth Coach RNs help to ensure that members most at risk are working toward making changes needed to prevent or delay the development of other serious conditions.

- **Hyperlipidemia** – Like Hypertension, members with this vascular condition can speak with their MyHealth Coach RN can assist those most at risk stay on track with exercise plans, nutrition education and medical compliance.

- **Oncology** (addressing prostate, skin, breast, colon and lung cancer) – For those members requiring the highest level of intervention, a dedicated MyHealth Coach RN works one-on-one with the participant to assist in reducing or stabilizing clinical severity. MyHealth Coach RNs also provide support through hospitalizations and any post-discharge plans needed.

- **Musculoskeletal** (addressing arthritis and osteoporosis) – By providing education and support to the highest utilizers, BCBSGa aims to help the member develop identification and intervention techniques that improve intervention timing and reduce the impact of future health costs for members afflicted with arthritis or osteoporosis.
• **Low Back Pain** – Though low back pain conditions often improve through conservative, non-surgical therapies, MyHealth Coach RNs are available to assist members in evaluating surgical alternatives and providing support throughout the member’s hospitalization, discharge, and rehabilitation needs.

### 24/7 NURSELINE PROGRAM

24/7 NurseLine is a toll-free, 24-hours a day, seven days a week, medical information service available to you and your covered family members. Whenever you or your family members experience a troubling health symptom, you may speak directly with a registered nurse. Nurse counselors are available to answer questions regarding medical procedures, health symptoms or prescription medications.

Nurse professionals are available to assist you with member referrals to appropriate healthcare providers, to self-help agencies, and/or to hospital emergency rooms/urgent care facilities, as necessary. The toll-free 24/7 NurseLine telephone number is 1-800-785-0006/TDD 1-800-368-4424.

**Emergency Room Services / Emergency Medical Services**

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

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

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

*Please be reminded that when a member is admitted to a National Network hospital, or to an Out-of-Network hospital, he/she must contact BCBSGa within 48 hours after the admission.*

The toll-free telephone number for BCBSGa is 1-800-233-5765/TDD 1-800-368-4424.

The use of 24/7 NurseLine is *voluntary.* You must decide what level of medical care is appropriate under emergency conditions. If you believe that you and/or your family member are facing a life-threatening situation, please act responsibly. Please go to the nearest medical facility or please call 911, if available in your area. If possible, we encourage you to contact 24/7 NurseLine to obtain timely emergency medical assistance.
The 24/7 NurseLine audio library is a medical information service/resource that is available to our plan participants. The audio library, developed by healthcare experts, provides extensive medical information on a variety of health-related topics. You may wish to access the audio library for information on a specific medical condition.

Please call the 24/7 NurseLine toll-free telephone number at anytime, day or night. Should you have additional questions regarding the medical information that you receive, you may transfer to a registered nurse and discuss the medical topic in greater detail. Please be reminded that the audio library should not be used as a substitute for your physician’s professional assistance.

The 24/7 NurseLine audio library information is available on the University System of Georgia website at http://www.usg.edu/hr/benefits/health_insurance/. The resource link is WebMD® Health Database.

EXPENSES THE POS HEALTHCARE PLAN DOES NOT COVER (Exclusions)

Some of the medical services, supplies, or treatments, that are not covered by the POS healthcare plan include, but are not limited to:

What’s Not Covered
Your coverage does not provide benefits for:

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

• **Behavioral Disorders** - Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or 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 Contract provides for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Neither physical nor occupational therapy is covered for Developmental Delay. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.

• **Biomicroscopy** - Biomicroscopy, field charting or aniseikonic investigation.

• **Care, Supplies, or Equipment** - Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant’s house or place of business, and adjustments made to vehicles.

• **Complications** - Complications of non-covered procedures are not covered.

• **Counseling** - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

• **Court-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 Contract is paying for an Intensive Care, cardiac care, or other special care unit.

• **Dental Care** - Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and
their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this SPD Booklet.

- **Drugs** - Any drug or other item which does not require a prescription.
- **Durable Medical Equipment** - The following items related to Durable Medical Equipment are specifically excluded:
  - Air conditioners, humidifiers, dehumidifiers, or purifiers;
  - Arch supports and orthopedic or corrective shoes;
  - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
  - Sterile water;
  - Deluxe equipment or premium services, such as motor driven chairs or beds, when standard equipment is adequate;
  - Rental or purchase of equipment if you are in a facility which provides such equipment;
  - Electric stair chairs or elevator chairs;
  - Physical fitness, exercise, or ultraviolet/tanning equipment;
  - Residential structural modification to facilitate the use of equipment;
  - Other items of equipment which BCBSGA feels do not meet the listed criteria.
- **Employer-Run Care** - Care given by a medical department or clinic run by your employer.
- **Experimental or Investigational** - Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called “services”) which are, in BCBSGA’s judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational 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.
- **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 or routine examinations and services.
- **Homes** - Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- **Hypnotherapy**.
- **Ineligible Hospital** - Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
• **Ineligible Provider** - Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.

• **Infertility** - Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or a combination thereof.

• **Injury or Illness** - Care, supplies, or equipment not Medically Necessary, as determined by BCBSGA, for the treatment of an Injury or illness.

• **Inpatient Mental Health** - Inpatient Hospital care for mental health conditions when the stay is:
  • determined to be court-ordered, custodial, or solely for the purpose of environmental control;
  • rendered in a home, halfway house, school, or domiciliary institution;
  • associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related marital, social, cultural or work 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 the Claims Administrator.

• **Medical Reports** - Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

• **Methadone** - Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency (unless the Contract has mental health outpatient benefits) and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.

• **Miscellaneous Care** - Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.

• **Non-Physician Care** - Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care Providers as listed in this Certificate Booklet.

• **Not Medically Required** - Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.

• **Obesity** –Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole
means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. 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, bioenergetic 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.
- **Personal Comfort Items** - Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest’s meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
- **Private Room** - Private room, except as specified as Covered Services.
- **Provider (Close Relative)** - Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
- **Routine Physical Examinations** - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Certificate Booklet.
- **Safe Surrounding** - Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
- **Sclerotherapy** - Sclerotherapy of extremity veins.
- **Self-Help** - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
- **Sexual Modification/Dysfunction Treatments** - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).
- **Shoes** - Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
- **Skilled Nursing Facility** - Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
- **Telehealth** - Telehealth consultations will not be reimbursable for the use of audio-only telephone, facsimile machine or electronic mail.
- **Thermograms** - Thermograms and thermography.
- **Transplants** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
  - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
  - Transportation, travel or lodging expenses for non-donor family members;
  - Donation related services or supplies, including search, associated with organ acquisition and procurement;
  - Chemotherapy with autologous, allogeneic or syngeneic 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 of chronic illnesses received outside the United States performed without authorization.
- **Vision** - Vision care supplies including but not limited to eyeglasses and contact lenses. Devices to correct vision.
- **Vision (Surgical Correction)** - Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- **Waived Fees** - Any portion of a Provider’s fee or charge which is ordinarily due from a Participant but which has been waived. If a Provider routinely waives (does not require the Participant to pay) a Deductible or Out-of-Pocket amount, BCBSGA will calculate the actual Provider fee or charge by reducing the fee or charge by the amount waived.
- **War** - Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans’ Administration or military medical facilities as required by law.
- **Workers’ Compensation** - Care for any condition or Injury recognized or allowed as a compensable loss through any Workers’ Compensation, occupational disease or similar law. **Exception:** Benefits are provided for actively employed partners and small business owners not covered under a Workers’ Compensation Act or similar law, if elected by the Group and additional Premium is paid.
WHEN YOUR POS HEALTHCARE PLAN COVERAGE ENDS

Your coverage, under the POS healthcare plan, will end on the last day of the month in which:

- You are no longer eligible to participate in the plan;
- You elect to withdraw from the plan during an open enrollment period;
- Your employment is terminated, except due to death;
- You fail to make any required employee contribution; or
- The POS healthcare plan is terminated.

Please be reminded that you may continue with your coverage under the POS healthcare plan, if you are on a campus-approved leave of absence.

Blue Cross Blue Shield of Georgia will issue a Certificate of Creditable Coverage to a member when his/her POS healthcare plan coverage ends. This Certificate of Creditable Coverage may be presented to a new employer to demonstrate proof of previous healthcare plan coverage. The BCBSGA Certificate of Creditable Coverage affords compliance with specific provisions of the federal Health Insurance Portability and Accountability Act (HIPAA).

WHEN POS HEALTHCARE PLAN COVERAGE FOR YOUR ELIGIBLE AND COVERED DEPENDENT(S) ENDS

Your POS healthcare plan provides coverage for a dependent until he/she attains age 26. On a dependent’s 26th birthday, his/her healthcare coverage will terminate. Healthcare coverage extended to your eligible and covered dependents (other than full-time students) will end on the last day of the month in which:

- Your dependent(s) ceases to be eligible;
- Your dependent(s) becomes eligible for coverage under the plan, as a University System of Georgia employee;
- You are no longer eligible to participate in the plan;
- You elect to withdraw from the plan during an open enrollment period;
- Your employment is terminated;
- You elect to reduce your level of benefit coverage: (1) from “family” coverage to “employee + child” or “employee + spouse” coverage or to “single” coverage; or (2) from “employee + child” or “employee + spouse” coverage to “single” coverage;
- You fail to make any required employee contribution; or
- The plan is terminated.
If your POS healthcare plan coverage ends, you and/or your dependents may be eligible for an extension of coverage under the special provisions of the plan. Please see the section entitled, “Coverage After Retirement”, located on the next page, or the section entitled, “Extended Coverage for Your Dependents After Your Death”, located on page 66 of this booklet.

**COVERAGE FOR ACTIVE EMPLOYEES AGE 65 OR OVER**

If a member continues to work past the age of 65, he/she may be eligible to access healthcare coverage under the POS healthcare plan and under Medicare Part A. If a member meets the eligibility requirements for participation in Medicare Part A, he/she should apply for these benefits with Social Security.

For an active employee who is age 65 and older, the POS plan will continue to provide primary healthcare coverage. If the member has enrolled in Medicare Part A, secondary healthcare coverage may be available under Medicare.

If an employee has a spouse who is age 65 or older, the spouse should apply for Medicare Part A and Part B, when eligible.

**COVERAGE AFTER RETIREMENT**

When a member retires from active service with the University System of Georgia, participation in the POS healthcare plan may be continued into retirement if the member complies with the requirements as prescribed by the Board of Regents Policy Manual. A member who enters retirement may continue with the same level (single, employee + child, employee + spouse, or family) of healthcare coverage that he/she had immediately prior to retirement. On page 24 of this booklet, information is provided regarding the University System of Georgia Retiree Annual Change Period.

Continued participation in the healthcare plan is voluntary. You will continue to pay your employee portion of the monthly premium. The institution from which you retired will continue to pay the employer’s share of your monthly premium.

The costs of healthcare plan premiums for employees, retirees and dependents of the University System of Georgia changes periodically. Your campus Human Resources/Personnel Office will notify you of any changes in plan costs and in employer/employee contribution rates.

If you carry “employee + child” or “employee + spouse” healthcare coverage or “family” healthcare coverage into retirement, and you predecease your spouse, your covered dependents will be permitted to continue their healthcare coverage.

Healthcare coverage for the spouse will continue until his/her death or remarriage. Coverage for dependent children would continue until they ceased to be eligible.
When a retired member of the University System of Georgia reaches age 65, it is strongly recommended that he/she apply for Medicare Part A and Part B. If a member meets the eligibility requirements for participation under both Medicare Part A and B, he/she should apply for these benefits with Social Security. If you are covered by both Medicare and the POS healthcare plan, your Medicare coverage will be primary. Your POS plan coverage will be secondary.

If an employee has a spouse who is age 65 or older, the spouse should apply for Medicare Part A and Part B, when eligible.

The University System of Georgia reserves the right to alter, modify or terminate these retiree healthcare benefits at any time and from time to time. Nothing in the Plan entitles retirees to lifetime healthcare benefits from the University System of Georgia.

EXTENDED HEALTHCARE COVERAGE FOR DEPENDENTS AFTER THE DEATH OF A COVERED EMPLOYEE

(A) Deceased University System of Georgia Employee With A Minimum of Ten Years of Service

A dependent, of an active employee who dies while in active service or in retirement, may remain as a participant of the POS healthcare plan under the following conditions:

- The deceased employee must have had at least ten years of continuous service in a benefits eligible position with the University System of Georgia; or

- The deceased employee must have had ten years of continuous service with the State of Georgia. The final two years of State of Georgia continuous service must have been with the University System of Georgia in a benefits eligible position.

The University System of Georgia will continue to pay the employer portion of healthcare plan premiums until the dependent ceases to be eligible. Healthcare coverage for a deceased member’s spouse will continue until his/her death or remarriage.

(B) Deceased University System of Georgia Employee With Less Than Ten Years of Service

A dependent, of an active employee who dies with less than ten years of service, may remain as a participant in the POS healthcare plan for no more than 12 consecutive months after the death of the employee. The University System of Georgia will pay the employer portion of the healthcare plan premiums for this 12 month period. After this 12-month period, a dependent may elect to continue his/her healthcare coverage through COBRA. However, the COBRA coverage period to which the dependent may be entitled due to the death of the employee will be reduced by this 12-month period of coverage. However, the COBRA coverage period to which the dependent may be entitled due to the death of the employee will be reduced by this 12-month period of coverage. For information regarding Your COBRA Rights, please see page 66 of this booklet.
FILING PAPER CLAIMS/USE OF PHYSICIAN WHO IS NOT A PROVIDER WITHIN THE NETWORK

If you receive medical care from a physician who is not a member of the network or the National POS/POS healthcare network, you will have one year from the date that such service was rendered to file a paper claim and receive reimbursement for covered charges.

Claims should be submitted to:
Blue Cross Blue Shield of Georgia
Post Office Box 7728
Columbus, GA 31908-7728
Telephone: 1-800-424-8950/TDD 404-842-8073

GENERAL INFORMATION REQUIRED TO FILE A CLAIM

In order to process your medical claim, the following information is required regardless of the provider. Plan benefits will be paid upon receipt of: (1) a completed claim form; and (2) provider documentation of medical treatment and/or services. The claim form must be filled out in its entirety. Any missing information may cause a delay in processing your reimbursement. The following information must be included on the claim form:

- Name of the contract holder; contract number; and group number, exactly as it appears on your member identification card;
- Provider documentation of medical treatment/services and detailed diagnosis; and
- A copy of the provider’s billing statement indicating:
  - The name of the patient;
  - The type of treatment or services rendered;
  - The date and charges for treatment or services;
  - The signature of the provider; and
  - Provider tax ID # and physical address.

Please retain a copy of all claim forms and bills for your records.
Claims forms are available and may be obtained from your campus Human Resources/Personnel Office, from the BCBSGA Customer Service department, or via electronic format from the University System of Georgia website at: http://www.usg.edu/hr/benefits/health_insurance/ or the BCBSGa website at www.bcbsga.com.
PLEASE NOTE:
The following do not meet the supporting documentation requirements for filing a paper claim: (1) a provider billing statement that reflects a “balance due” amount; (2) a cash receipt issued to a member from a provider; and/or (3) a canceled check reflecting a member’s payment for provider services.

FILING PAPER CLAIMS/FOREIGN CLAIMS WHILE TRAVELING ABROAD

If a member receives medical care while traveling outside of the United States, he/she will be required to pay the provider at the time that medical services are rendered. The member will have one year from the date that the medical services were rendered to file a paper claim and receive reimbursement for covered charges.

Claims should be submitted to:
BlueCard Worldwide® Service Center
P O Box 72017
Richmond, VA 23255-2017 USA

For inpatient care at a BlueCard Worldwide® hospital that was arranged through the BlueCard Worldwide Service Center, call 1-800-810-BLUE (2583), you only pay the provider the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance). The provider files the claim for you.

For all outpatient and professional medical care, you pay the provider and submit a claim. You may also have to pay the hospital (and submit a claim) for inpatient care obtained from a non-BlueCard Worldwide® hospital or when inpatient care was not arranged through the BlueCard Worldwide Service Center.

To submit a claim, you complete an International Claim Form and send it to the BlueCard Worldwide Service Center. The claim form must be completed fully otherwise it will be returned to you and payment will be delayed.

For questions, you may contact your local BCBSGa Customer Service Unit or the BlueCard Worldwide Service Center Outside the U.S. (call collect): 1-800-673-1177.
Plan benefits will be paid upon receipt of: (1) a completed claim form; and (2) an itemized bill for medical treatment and/or services. The member will be required to have the itemized bill translated into English prior to submitting a paper claim to BCBSGA. To expedite the processing of such claims, BCBSGA requests that the billed amount be converted to an equivalent United States currency rate.
The claim form must be filled out in its entirety. Any missing information may cause a delay in processing your reimbursement.

All foreign pharmacy claims must be submitted directly to BCBSGa.

**PLEASE NOTE:**

An explanation of benefit (EOB) form and reimbursement for covered medical treatment/services will be mailed to a member’s United States mailing address. BCBSGA **will not** mail this type of information to any address outside the United States.

Please be reminded that the member must pay for provider services rendered outside of the United States. BCBSGA **will not** reimburse a non-United States healthcare provider.

**DENIAL OF A CLAIM BY BCBSGA**

If you have a medical claim that is denied, you will receive written notification from BCBSGA. The denial notice will include:

- The specific reason(s) for the denial;
- A reference to the plan provision(s) that supports the denial by BCBSGA;
- The clarification of information required from the member/provider to complete the processing of the claim; and
- An explanation regarding the necessity for providing additional information.

If a time extension to process a claim is required by BCBSGA, you will be notified in writing and provided with an explanation for the reason for the extension.

**APPEALING A DENIED CLAIM**

A member has a right to express concerns about a denied claim and to expect an unbiased resolution of his/her issues. BCBSGA is an important informational resource that should be initially contacted to answer member inquiries and to confirm the types of coverage that have been adopted and implemented for the POS healthcare plan.

If a medical claim is denied, the member may appeal this decision to BCBSGA **within 180 days** of the date that the claim was denied.

Please contact the BCBSGA Customer Service department at 1-800-424-8950/TDD 404-842-8073. Please share your concerns regarding a denied medical claim with the BCBSGA customer service representative.
When discussing a claim, please provide the following information:

- Contract holder name and identification number;
- Patient name and address;
- Provider name and address (hospital and/or physician);
- Date/dates of service; and
- Type of service received.

You have the right to submit a written inquiry regarding your denied medical claim. Written inquiries should be directed to:

Blue Cross Blue Shield of Georgia  
Post Office Box 7728  
Columbus, GA 31908-7728

You should receive a written response from BCBSGA regarding your initial written inquiry within 30 calendar days.

Following the review process by BCBSGA, a member may submit a final appeal to the plan administrator. The plan administrator will not accept any member appeal until the entire BCBSGA process has been completed. The member will be required to provide the plan administrator with all supporting documentation presented at the respective levels of the BCBSGA appeal process. The plan administrator will render a final decision.

**APPEALING A DENIED Precertification**

Please contact BCBSGa at 1 (800)233-5765 to request an appeal on a denied precertification. Request may be made by the member or physician.

**ASSIGNMENT OF BENEFITS**

The process for the assignment of benefits permits a member to have his/her plan benefits paid directly to a provider (physician/hospital) for medical treatment/services that have been rendered. Healthcare benefits are automatically paid to:

- Physicians, hospitals, and ancillary providers that are providers in the Network; Physicians, hospitals, and ancillary providers that are providers in the National Network;
- Mental health providers in the BCBSGa network; and
- Centers of Expertise for the *Organ and Tissue Transplant* program.
RIGHT OF REIMBURSEMENT

The Plan may require reimbursement from a covered member for benefits paid to the covered member for an injury or illness involving negligence or misconduct of a third party, if the covered member is “made whole”. A covered member is made whole if the covered member recovers amounts under a settlement or a judgment against a third party, which is more than the sum of all economic and non-economic losses incurred as a result of an injury or illness. The amount of any reimbursement claim by the Plan will be reduced by the pro rata amount of the attorney’s fees and expenses of litigation incurred by the covered member in bringing a claim against the third party. The Plan has the right to seek a declaratory judgment in court to share in the proceeds of any settlement or judgment where the covered member claims he or she has not been made whole.

Any person seeking recovery for personal injury from a third party on behalf of the covered member, which is related to a claim for which the Plan has paid benefits, must provide notice of the claim, by certified mail or statutory overnight delivery to the Plan. This notice must be provided no later than 10 days prior to the consummation of any settlement or commencement of any trial. Once the notice is received the Plan will provide a notice to the covered member for any claims for reimbursement.

ADMINISTRATIVE INFORMATION

COORDINATION OF BENEFITS (COB)

A number of healthcare plan members and enrolled dependents may be covered under another healthcare plan that provides medical benefits on a group-insurance basis. If you are such a member, you should be informed about the POS plan’s provision for “Coordination of Benefits (COB)”. The plan member is responsible for notifying BCBSGa of any COB changes.

The POS plan’s (COB) provision stipulates that, when there is multiple coverage by two or more group-insurance medical benefit plans, reimbursement by the Board of Regents POS plan will not exceed 100% of the covered charges incurred. Covered charges do not include member penalties assessed for plan non-compliance.

The COB provision applies to any group-insurance medical benefit plan. Examples would include governmental programs, such as Medicare; or the employer of a spouse who offers group-insurance medical benefits. COB does not apply to an individual policy for healthcare coverage, for which the member pays the total premium directly to the insurer.

To administer the COB provision, it must be determined which group-insurance medical plan is deemed to have “primary” coverage. The primary plan will be required to initially process and pay any covered medical claims. This generally means that the primary plan will pay for the majority of the costs associated with such claims. Any other group-insurance medical plan(s) is deemed to have “secondary” coverage responsibilities.
The decision, regarding which group-insurance medical plan is “primary”, is made as follows:

1. A plan without a Coordination of Benefits (COB) provision is primary over a plan with COB provision.

2. A group-insurance medical plan that covers an individual as an active or retired employee is primary over a group-insurance medical plan that covers an individual as a dependent.

An exception to this policy is:

An institution has a retiree of the University System of Georgia (USG). The USG retiree has healthcare coverage with: (1) the University System of Georgia; (2) Medicare; and (3) is covered as a dependent under his/her spouse’s active group healthcare plan. In this case, the spouse’s healthcare plan coverage is primary; Medicare coverage is secondary; and the retiree’s USG healthcare plan has the third or tertiary level of responsibility.

3. For children, the healthcare plan of the parent whose birthday occurs earlier in the calendar year is deemed to be primary. If both parents’ birthdays occur on the same day, the healthcare plan that has insured the parent for the longest period of time is primary. If one of the plans does not have the parent birthday rule, the father’s healthcare plan is primary.

4. For children of separated or divorced parents:
   (A) When a court decree has determined that one parent has financial responsibility for medical, dental or other healthcare expenses of a child, the healthcare plan of the parent with court-decreed financial responsibility is primary to any other plan covering the child (regardless of which parent has custody).

   (B) When a court decree states that the parents will share joint custody, without specifying which parent has financial responsibilities for medical or dental care expenses of a child, the plan providing primary coverage for the child, will follow the sequence of benefit determination rules presented below:

   1. The healthcare plan of the parent whose birthday occurs earlier in the calendar year is primary;
   2. When both parents’ birthdays occurs on the same day, the healthcare plan that has insured the parent for the longest period of time is primary; and
   3. If one of the plans does not have the parent birthday rule, the father’s healthcare plan is primary.

   (C) In the absence of court-decreed financial responsibility:

   1. For healthcare plans that cover a child of separated or divorced parents who have not remarried, the healthcare plan of the parent with custody is deemed to be primary.

   2. For healthcare plans that cover a child of remarried parent(s):
• The healthcare plan of the remarried parent, with custody, is deemed to be primary;
• The healthcare plan of the step-parent is deemed to be secondary; and
• The healthcare plan of the biological parent, without custody, is deemed to have the third level of healthcare payment responsibility.

5. The healthcare plan that covers an insured individual as an active employee is primary over a healthcare plan that covers a retiree or laid-off employee. The same process is true for an active employee covered by his/her employer’s group-insurance medical plan who is also covered as a dependent under a retiree’s/laid-off employee’s group-insurance medical plan. An active employee’s healthcare plan will have primary coverage responsibilities.

Benefits under the Board of Regents POS healthcare plan will also be coordinated with benefits provided by the federal Medicare program. If a member has both USG POS healthcare coverage and Medicare coverage, COB procedures will be established as follows:

• If you are covered under the POS healthcare plan as an active employee or as the spouse of an active employee, the USG POS plan will be primary.

Your network provider will file medical claims with the USG POS plan initially and then, with Medicare. In many cases, your healthcare provider will file your medical claims with the USG POS healthcare plan and Medicare simultaneously.

• If you are covered under the USG POS healthcare plan as a retiree or as the spouse of a USG retiree, and you are age 65 or older, Medicare will be primary.

If you return to active employment with another employer after you reach age 65 and you are covered by the new employer’s group-insurance healthcare plan, then: (1) your new employer’s healthcare plan will be primary; (2) Medicare coverage will be secondary; and (3) the USG healthcare plan will be considered to have a third or tertiary coverage responsibilities.

YOUR COBRA RIGHTS

Summary. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) you or your covered dependents have the option of continuing healthcare coverage under the Plan when you or your covered dependents would otherwise lose coverage. Terms, conditions, and costs for healthcare coverage are identified below. If your coverage is continued under COBRA, BCBSGa must continue to review and approve all medical treatment/services that are provided for you and your covered dependents. You will be required to comply with all Plan requirements to receive covered benefits.
What is COBRA Coverage? COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event”. Qualifying events are listed below. After a qualifying event occurs, and any required notice is properly given, COBRA coverage must be offered to each person losing coverage who is a “qualified beneficiary”. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Each qualified beneficiary has the right to continue the level of coverage in effect on the day before the qualifying event (or a lesser level of coverage). Under the Plan, qualified beneficiaries who elect COBRA must pay for the COBRA coverage.

You may elect COBRA coverage if any of the following qualifying events occur:

- Coverage for you and your covered dependents can be continued for up to 18 months if:
  - You terminate your employment with the University System of Georgia, for reasons other than gross misconduct; or
  - You have a reduction in your work commitment to less than half time. To be eligible for benefits coverage, you must be employed by the University System of Georgia for at least 30 hours per week on a regular basis.
- There are changes in family circumstances that would permit a covered dependent to extend his/her COBRA coverage from an initial 18-month eligibility period up to a maximum of a 36-month eligibility period. Presented below are the conditions that would permit this extension of COBRA healthcare coverage for up to 36 months.
  - Coverage may be provided for your spouse and dependents, if you die;
  - Coverage may be provided for your spouse and dependents, if you legally separate or divorce;
  - Coverage may be provided for your child, when the child is no longer an eligible dependent under the POS healthcare plan; or,
  - Coverage may be provided for your spouse and dependents when you become Medicare eligible, usually at age 65.
- Under certain conditions, COBRA healthcare coverage may be granted for a period of 29 months:
  - A covered member of your family is disabled at the time of the loss of your healthcare coverage.
- Under certain conditions, COBRA healthcare coverage may be extended from an initial 18-month eligibility period to a 29-month eligibility period:
  - A covered member of your family becomes disabled while you are receiving COBRA healthcare benefits.

Disability Extension of COBRA Coverage. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify your Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. This extension is available only for qualified beneficiaries who are COBRA coverage because of a qualifying event that was the covered employee’s termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered employee’s termination of employment.
or reduction in hours and must last at least until the end of the COBRA coverage period that would be available without the disability extension. (Generally 18 months). The disability extension is available only if you notify your Employer in writing of the Social Security Administration’s determination of disability within 60 days after the later of:

- The date of the Social Security Administration’s disability determination;
- The date of the covered employee’s termination of employment or reduction in hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the covered employee’s termination of employment or reduction in hours.

You also must provide this notice within 18 months after the covered employee’s termination of employment or reduction of hours in order to be entitled to a disability extension. **If notice is not provided during the 60-day notice period and within 18 months after the covered employee’s termination of employment or reduction in hours, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

**Second Qualifying Event.** If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee’s termination of employment or reduction in hours, the spouse and dependent children receiving COBRA coverage can get up to an additional 18 months of coverage if proper notice of the second event is given to the Plan. The extension for a second qualifying event is available only if you notify the Employer in writing of the second qualifying event within 60 days after the date of the second qualifying event. **If notice is not provided during the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

**Effect of Entitlement to Medicare.** When the qualifying event is termination of employment or reduction in hours and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment ends, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement which is equal to 28 months after the date of the qualifying event (36 months less 8 months). The COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before termination of employment or reduction in hours.

**Election COBRA.** Qualified beneficiaries entitled to COBRA coverage have 60 days from the date of notice from the Plan to elect COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA. Covered members and spouses may elect COBRA on behalf of all the qualified beneficiaries and parents may elect COBRA on behalf of their children. **ANY QUALIFIED BENEFICIARY FOR WHOM COBRA IS NOT ELECTED WITHIN THE 60 DAY ELECTION PERIOD WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**
If the POS healthcare plan continues to provide coverage for any period of time after a COBRA qualifying event occurs, such time will be counted against the 18, 29, or 36 months of COBRA eligibility.

The cost for COBRA healthcare coverage will be the combined employer and employee premium contribution amounts, plus an additional 2% administrative fee. The member cost for COBRA healthcare coverage would, therefore, be 102% of the total indemnity healthcare premiums. The employee/employer premium costs for the indemnity healthcare plan changes periodically. As changes in premiums for the indemnity plan change, costs for COBRA healthcare coverage will change accordingly.

COBRA healthcare premiums must be paid to your campus Human Resources/Personnel Office. A member must make an election for COBRA healthcare coverage within 60 days (after the date of the COBRA continuation notice) of his/her loss of University System of Georgia healthcare coverage.

The member must submit his/her initial premium payment within 45 days of election of COBRA coverage or COBRA healthcare continuation rights will be forfeited. A member will be required to remit all premiums to his/her institution from the date of his/her initial loss of University System of Georgia healthcare coverage.

Thereafter, the member will be responsible for remitting monthly premiums to his/her campus Human Resources/Personnel Office, consistent with an institutionally determined schedule of payment.

**PLEASE NOTE:**

It is the member’s responsibility to notify his/her campus Human Resources/Personnel office for all qualifying events other than the end of the covered member’s employment or reduction in hours or death of the covered member. For other qualifying events (divorce or legal separation of the covered member and spouse, or a child’s losing eligibility for the University System of Georgia healthcare coverage) a COBRA election will be available only if you provide notice in writing within 60 days after the later of (1) the date of the qualifying event and (2) the date on which the qualified beneficiary loses or would lose coverage under the terms of the Plan as a result of the qualifying event. Oral notice, including notice by telephone is not acceptable. If the notice is mailed, it must be postmarked no later than the last of the notice period. IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE REQUIRED NOTICE IS NOT PROVIDED DURING THE 60 DAY PERIOD, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

COBRA healthcare coverage will end prior to the end of the 18-month, 29-month or 36-month maximum eligibility participation period if:

- A COBRA-covered disabled family member who recovers from his/her disability after his/her initial 18-month eligibility period and prior to the conclusion of the 29-month COBRA eligibility period;
The member fails to remit his/her required COBRA healthcare premium within the institutionally approved schedule for payment;

- The University System of Georgia healthcare plan is terminated;
- After election, a qualified beneficiary becomes covered under another group health plan other than a group health plan which may limit a qualified beneficiary’s coverage because it involves a pre-existing condition;
- After election, a qualified beneficiary becomes entitled to receive benefits under Medicare, or
- Termination for cause (e.g., submission of a fraudulent claim).

The qualified beneficiary must notify the Plan within 30 days after he becomes covered by another group health plan or entitled to Medicare.

**Other Qualifying Beneficiaries.** A child born to, adopted by, or placed for adoption with a covered member during a period of COBRA coverage is considered to be a qualified beneficiary provided that the covered employee is a qualified beneficiary and the covered employee elected COBRA for himself or herself. The child’s COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment and it lasts for as long as COBRA coverage lasts for the other family members. To be enrolled in the Plan the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

**Alternate Recipients Under QMSCOS.** A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMSCO) received by the Employer during the covered employee’s period of employment is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

The broad mission and extensive scope of operations of the Board of Regents of the University System of Georgia, including the constituent colleges and universities of the University System of Georgia (collectively, the “Board”), necessitates that the Board collect, maintain, and, where necessary, disseminate health information regarding the Board’s students, employees, volunteers, and others. For example, the Board collects medical information through its various medical and dental hospitals, clinics, and infirmaries, through the administration of its various medical and life insurance programs, and through its various environmental health and safety programs. The Board protects the confidentiality of individually identifiable health information that is in its possession. Such health information, which is protected from unauthorized disclosure by Board policies and by state and federal law, is referred to as “protected health information,” or “PHI.”

PHI is defined as any individually identifiable health information regarding an employee’s, a student’s, or a patient’s medical/dental history; mental or physical condition; or medical treatment. Examples of PHI include patient name, address, telephone and/or fax number,
electronic mail address, social security number or other patient identification number, date of birth, date of treatment, medical treatment records, medical enrollment records, or medical claims records.

The Board will follow the practices that are described in its Notice of Privacy Practices (“Notice”). The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in conspicuous locations.

Permitted Uses and Disclosures of PHI

The following categories describe the different ways in which the Board may use or disclose your PHI. We include some examples that should help you better understand each category.

The Board may receive, use, or disclose your PHI to administer your health and dental benefits plan. Please be informed that the Board, under certain conditions and circumstances, may use or disclose your PHI without obtaining your prior written authorization. An example of this would be when the Board is required to do so by law.

For Treatment. The Board may use and disclose PHI as it relates to the provision, coordination, or management of medical treatment that you receive. The disclosure of PHI may be shared among the respective healthcare providers who are involved with your treatment and medical care. For example, if your primary care physician needs to use/disclose your PHI to a specialist, with whom he/she consults regarding your condition, this would be permitted.

For Payment. The Board may use and disclose PHI to bill and collect payment for healthcare services and items that you receive. The Board may transmit PHI to verify that you are eligible for healthcare and/or dental benefits. The Board may be required to disclose PHI to its business associates, such as its claims processing vendor, to assist in the processing of your health and dental claims. The Board may disclose PHI to other healthcare providers and health plans for the payment of services that are rendered to you or to your covered family members by such providers or health plans.

For Healthcare Operations. The Board may use and disclose PHI as part of its business operations. As an example, the Board may require a healthcare vendor partner (referred to as a “business associate”) to survey and assess constituent satisfaction with healthcare plan design/coverage. Constituent survey results assist the Board in evaluating quality of care issues and in identifying areas for needed healthcare plan improvements. Business associates are required to agree to protect the confidentiality of your individually identifiable health information.

The Board may disclose PHI to ensure compliance with applicable laws. The Board may disclose PHI to healthcare/dental providers and health/dental plans to assist them with their required credentialing and peer review activities. The Board may disclose PHI to assist in
the detection of healthcare fraud and abuse. Please be reminded that the lists of examples that are provided are not intended to be either exhaustive, or exclusive.

**As Required by Law and Law Enforcement.** The Board must disclose PHI when required to do so by applicable law. The Board must disclose PHI when ordered to do so in a judicial or administrative proceeding. The Board must disclose PHI to assist law enforcement personnel with the identification/location of a suspect, fugitive, material witness, or missing person. The Board must disclose PHI to comply with a law enforcement search warrant, a coroner’s request for information during his/her investigation, or for other law enforcement purposes.

**For Public Health Activities and Public Health Risks.** The Board may disclose PHI to government agencies that are responsible for public health activities and to government agencies that are responsible for minimizing exposure to public health risks.

The Board may disclose PHI to government agencies that maintain vital records, such as births and deaths. Additional examples in which the Board may disclose PHI, as it relates to public health activities, include assisting in the prevention and control of disease; reporting incidents of child abuse or neglect; reporting incidents of abuse, neglect, or domestic violence; reporting reactions to medications or product defects; notifying an individual who may have been exposed to a communicable disease; or, notifying an individual who may be at risk of contracting or spreading a disease or condition.

**For Health Oversight Activities.** The Board may disclose PHI to a government agency that is authorized by law to conduct health oversight activities. Examples in which the Board may disclose PHI, as it relates to health oversight activities, include assisting with audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities that are necessary to monitor healthcare systems, government programs, and compliance with civil rights laws.

**Coroners, Medical Examiners, and Funeral Directors.** The Board may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent; for determining a cause of death; or, otherwise as necessary, to enable these parties to carry out their duties consistent with applicable law.

**Organ, Eye, and Tissue Donation.** The Board may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

**Research.** Under certain circumstances, the Board may use and disclose PHI for medical research purposes.

**To Avoid a Serious Threat to Health or Safety.** The Board may use and disclose PHI to law enforcement personnel or other appropriate persons. The Board may use and disclose PHI to prevent or lessen a serious threat to the health or safety of a person or the public.
Specialized Government Functions. The Board may use and disclose PHI for military personnel and veterans, under certain conditions, and if required by the appropriate authorities. The Board may use and disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities.

The Board may use and disclose PHI for the provision of protective services for the President of the United States, other authorized persons, or foreign heads of state. The Board may use and disclose PHI to conduct special investigations.

Workers’ Compensation. The Board may disclose PHI for worker’s compensation and similar programs. These programs provide benefits for work-related injuries or illnesses.

Appointment Reminders/Health Related Benefits and Services. The Board and/or its business associates may use and disclose your PHI to various other business associates that may contact you to remind you of a healthcare or dental appointment. The Board may use and disclose your PHI to business associates that will inform you of treatment program options, or, of other health related benefits/services such as Condition Care Management Programs.

Disclosures for HIPAA Compliance Investigations. The Board must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when so requested. The Secretary may make such a request of the Board to investigate its compliance with privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures of Your PHI to Which You Have An Opportunity to Object

You have the opportunity to object to certain categories of uses and disclosures of PHI that the Board may make:

Patient Directories. Unless you object, the Board may use some of your PHI to maintain a directory of individuals in its hospitals or provider facilities. This information may include your name, your location in the facility, your general condition (e.g. fair, stable, etc.), and your religious affiliation. Religious affiliation may be disclosed to members of the clergy. Except for religious affiliation, the information that is maintained in a patient directory may be disclosed to other persons who request such information by referring to your name.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, the Board may disclose your PHI to a family member, another relative, a friend, or another person whom you have identified as being involved with your healthcare, or, responsible for the payment of your healthcare. The Board may also notify these individuals concerning your location or condition.
**Fundraising Activities.** Unless you object, the Board may disclose your PHI to contact you for fundraising efforts to support the Board, its related foundations, and/or its cooperative organizations. Such disclosure would be limited to personal contact information, such as your name, address and telephone number. The money raised in connection with these fundraising activities would be used to expand and support the provision of healthcare and related services to the community.

If you object to the use of your PHI in any, or all, of the three instances identified above, please notify your campus or facility privacy officer, in writing.

**Other Uses and Disclosures of Your PHI**

**For Which Authorization Is Required**

Certain uses and disclosures of your PHI will be made only with your written authorization. Please be advised that there are some limitations with regard to your right to object to a decision to use or disclose your PHI.

**Regulatory Requirements.** The Board is required, by law, to maintain the privacy of your PHI, to provide individuals with notice of the Board’s legal duties and PHI privacy practices, and to abide by the terms described in this Notice.

The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise its Notice and post a new Notice in conspicuous locations. You have the following rights regarding your PHI:

You may request that the Board restrict the use and disclosure of your PHI. The Board is not required to agree to any restrictions that you request, but if the Board does so, it will be bound by the restrictions to which it agrees, except in emergency situations.

You have the right to request that communications of PHI to you from the Board be made by a particular means or at particular locations. For instance, you might request that communications be made at your work address, or by electronic mail, rather than by regular US postal mail. Your request must be made in writing. Your request must be sent to the privacy officer on your campus or facility. The Board will accommodate your reasonable requests without requiring you to provide a reason for your request.

Generally, you have the right to inspect and copy your PHI that the Board maintains, provided that you make your request in writing to the privacy officer on your campus or your facility. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. In some cases, the Board may provide you with a summary of the PHI that you request, if you agree in advance to a summary of such information and to any associated fees. If you request copies of your PHI, or agree to a summary of your PHI, the Board may impose a reasonable fee to cover copying, postage, and related costs.
If the Board denies access to your PHI, it will explain the basis for the denial. The Board will explain your opportunity to have your request and the denial reviewed by a licensed healthcare professional (who was not involved in the initial denial decision). This healthcare professional will be designated as a reviewing official. If the Board does not maintain the PHI that you request, but it knows where your requested PHI is located; it will advise you how to redirect your request.

If you believe that your PHI maintained by the Board contains an error or needs to be updated, you have the right to request that the Board correct or supplement your PHI.

Your request must be made in writing to the privacy officer on your campus or in your facility. Your written request must explain why you desire an amendment to your PHI.

Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. The Board generally can deny your request, if your request for PHI: (i) is not created by the Board, (ii) is not part of the records the Board maintains, (iii) is not subject to being inspected by you, or (iv) is accurate and complete.

If your request is denied, the Board will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial, (ii) if you do not file a statement of disagreement, to submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the Board’s denial attached, and (iii) complain about the denial.

You generally have the right to request and receive a list of the disclosures of your PHI that the Board has made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003).

The list will not include disclosure for which you have provided a written authorization, and will not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations, (ii) made to you, (iii) for the Board’s patient directory or to persons involved in your healthcare, (iv) for national security or intelligence purposes, or (v) to correctional institutions or law enforcement officials.

You should submit any such request to the privacy officer on your campus or in your facility. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will respond to you regarding the status of your request. The Board will provide the list to you at no charge. If you, however, make more than one request in a year, you will be charged a fee for each additional request. You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically. This notice may be found at the Board website address, www.usg.edu/legal/. To obtain a paper copy of this notice, please contact your campus or facility privacy officer.

You may complain to the Board if you believe your privacy rights, with respect to your PHI, have been violated by contacting the privacy officer on your campus or in your facility. Your
must submit a written complaint. The Board will in no manner penalize you or retaliate against you for filing a complaint regarding the Board’s privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You may contact the Secretary by calling 1-866-627-7748 (outside of metropolitan Atlanta) or (404) 562-7886 (in metropolitan Atlanta).

If you have any questions about this notice, please contact the Human Resources office on your campus or in your facility. For additional information, please contact the privacy officer on your campus or facility.

Effective Date: April 14, 2003

**PLEASE NOTE:**
On the following page you will find the CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION form. This form provides a spouse or another person/class of persons (organization) with the authority to act on behalf of another member. A signed authorization form provides access to PHI (protected health information) for an individual/organization other than the contract holder.

Should you need to access PHI for another individual, we ask that you photocopy this form and submit the completed form to your campus Human Resource/Personnel Office. Your institutional Human Resource/Personnel Office will forward a copy to the vendor (Business Associate/Agent) associated with your request.

Should you have any questions regarding the use of this form, please contact your campus Human Resource/Personnel Office for assistance.

**CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION**

This authorization form applies only to the release and disclosure of protected health information (PHI). This authorization is not for treatment or intended for any other purpose.

By signing this form, I authorize my college, my university, my facility, or the University System office and Business Associates/Agents to use, release, or disclose the protected health information described below to:

Name and address of person/organization to whom information may be sent:  
____________________________________________________________________________

Transmit this information on or about (information will not be resent absent reauthorization): ___/___/____.

This authorization expires upon fulfillment of this request unless special circumstances apply.

Purpose for disclosure: ____________________________________________________________
I authorize the following information to be sent to the address above:

___ Copies of all medical records for the period ___/___/___ to ___/___/___.

___ Copies of information described below for period ___/___/___ to ___/___/___.

___ History and Physical Examination     ___ Lab Reports       ___ Reports From Physicians

___ Other (specify) ____________________________________________________________

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted diseases (STD); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

Please include on a separate piece of paper any other special instructions or limitations.

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of my college, university, facility, or University System policies and procedures for HIPAA Compliance and any changes thereto which may be associated with this authorization. I have been provided an opportunity to discuss any concerns I may have about the use or misuse of my health information with my institutional or facility privacy officer or other appropriate personnel.

I understand that my institution or facility, the University System of Georgia, or the Board of Regents of the University System of Georgia assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release the Board of Regents of the University System of Georgia and its agents and employees from all legal liability that may arise from this authorization.

Name (please print): ___________________________________________________________
Address:____________________________________________________________________
Telephone: (____)_____________________  Fax: ____)__________________________
Group No.: __________________________  Group Name:________________________
Member ID Number: __________________  Social Security Number:________________

Signed:_______________________________________________________________________
Date of Birth:___________________________ Date this Authorization Executed:________

If the signature above is not that of the person whose medical records are authorized to be released, I am acting for the person whose medical records are being authorized for release: My relationship to such person is:__________________________________________________
Signed:_______________________________________________________________________
The person whose medical records are hereby authorized for release or that person’s representative may revoke this authorization by notifying in writing the privacy officer at the person’s university, college or facility. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is otherwise prohibited by the Health Insurance Portability and Accountability Act of 1996. Federal law also requires a statement that there is a potential for the protected health information released under this authorization to be subject to redisclosure by the recipient.

FORM CREATED 29 JAN 03

**FUTURE OF THE PLAN**

The Board of Regents of the University System of Georgia is the plan sponsor for the self-insured POS healthcare plan. While the University System of Georgia expects the POS healthcare plan to remain in effect, the University System of Georgia reserves the right to change the plan, or any benefit under the plan, from time to time; or to discontinue the plan, or any benefit under the plan, at any time.

**EMPLOYMENT RIGHTS NOT IMPLIED**

Your participation in the POS healthcare plan is not a contract of employment - it does not guarantee you continued employment with the University System of Georgia. Nor does it limit the University System of Georgia’s right to discharge you, without regard to the effect that your discharge would have on your rights under the POS healthcare plan. If you quit or if you are discharged, you have no right to future benefits from the plan except as specifically provided in this booklet and the benefit plan document.

**GLOSSARY OF TERMS**

This section of your health plan booklet provides terminology and phrases used throughout this document.

**Acute Care**
Care provided when such services are medically necessary and immediately required as a result of a sudden onset of illness or injury.

**Balance Billing**
The dollar amount charged by a provider that is in excess of the plan’s allowed amount for medical care or treatment. Amounts that are balance billed by a provider are the member’s responsibility. Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).

The University System of Georgia POS healthcare plan does not have the legal authority to intervene when a non-participating provider balance bills the member. Therefore, the healthcare plan cannot reduce or eliminate balance-billed amounts. The healthcare plan will not make additional payments above the plan allowed benefit limits.
Coinsurance

Coinsurance is the portion of the covered allowed charges that a member must pay, after he/she has met the appropriate deductible. If the healthcare plan covers 90% of the cost for a particular benefit, the member would be responsible for the remaining 10% of covered charges. The 10% of covered allowed charges, paid by the member, is deemed to be the coinsurance amount.

Contract Year

A period of one year commencing on the effective date (or renewal date) of a healthcare plan contract and ending at 12:00 midnight on the last day of the one year period. The contract year for the University System of Georgia begins on January 1 and concludes on December 31.

Co-payment

A co-payment is a fixed dollar amount that a member must pay for a particular service or item, such as a member co-payment for a prescription medication.

Covered Charges

The portion of a member’s billed charges for medical treatment, services, or supplies that will be reimbursed by the healthcare plan.

Custodial Care

Custodial care is any type of care, including room and board, that: (a) does not require the skills of a professional or technical healthcare provider; (b) is not furnished by, nor is under the supervision of, such a professional or technical healthcare provider; (c) does not, otherwise, meet the requirements of a post-hospital skilled nursing facility care; or (d) is a level of care, such that a member has reached his/her maximum level of physical or mental function, and is not likely to make further significant improvements. Custodial care includes, but is not limited to, any type of care in which the primary purpose of care is to attend to the member’s activities of daily living. Such care does not entail, nor require, the continuing attention or observation by trained medical or paramedical healthcare providers. Generally, care is considered custodial, if it can be provided by an untrained adult with little or no supervision.

Deductible

A deductible is a fixed dollar amount that a member must pay out-of-pocket, each plan year, before the healthcare plan will begin to pay for covered benefits.

Emergency Care

Emergency care is medical care that is provided for a sudden, severe, and/or unexpected illness/injury. If such care/treatment were not provided immediately, the results could be life threatening or could result in permanent impairment of bodily functions.

Explanation of Benefits (EOB)

An Explanation of Benefits (EOB) is an itemized statement of member-incurred medical charges. An EOB will identify paid or denied provider charges following the processing of a filed healthcare claim.
Hospice Care

*Hospice care* is a form of medical care that is provided for a patient who has been physician-certified as being terminally ill. *Hospice care* may be rendered in an inpatient or outpatient setting. The life expectancy of a hospice patient is generally deemed to be six months or less.

Hospital-based Physicians

Hospital-based physicians include, but are not limited to, anesthesiologists, emergency room physicians, pathologists, and radiologists.

Inpatient

A member, who is admitted to a hospital for medical treatment or services, and for whom, a room and board charge is paid. To be considered as *inpatient*, a hospital confinement must be for a period of at least 24 hours.

Maximum Allowed Amount

The Maximum Allowed Amount is the maximum amount of reimbursement the Claims Administrator 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.

Medical Utilization Management

*Medical Utilization Management* is a program that is administered by the Claims Administrator for all inpatient, and for specific outpatient, medical/surgical treatments and diagnostic tests. To access benefits coverage, the Claims Administrator must determine if: (1) a procedure is medically necessary; and/or (2) if an appropriate and alternative treatment is available. For additional information, please see page 38 of this booklet.

Medically Necessary

A service or treatment, which in the judgment of the healthcare plan, is both appropriate and consistent with a medical diagnosis. To meet the plan’s criteria for medical necessity, any service or treatment must be widely accepted professionally within the United States as effective, appropriate, and essential. The treatment or service must be based on recognized standards of the healthcare specialty involved. The *medically necessary* treatment or service may not be experimental in nature; educational; or primarily for research or investigations.

Mental Health Disorders

*Mental health disorders* include mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and/or drug, alcohol or chemical dependency. *Mental health disorders* may be organic; non-organic; biological; non-biological; genetic; of chemical origin; of non-chemical origin; irrespective of cause, basis or inducement.

Non-Covered Charges

Services that are not covered by the healthcare benefit plan design.
Outpatient
A member who receives treatment from a hospital, urgent care facility or outpatient facility and is released to return home following treatment. To be considered as *outpatient*, treatment received in a facility must be for a period of less than 24 hours.

Out-of-Pocket Limit (Stop Loss)
An *out-of-pocket limit* is the maximum amount of healthcare plan expenses that a member will be required to pay during a plan year. Out-of-pocket expenses include member deductibles and member co-insurance payments required on an annual plan year basis. Once a member reaches his/her *out-of-pocket limit*, the healthcare plan will pay for 100% of covered expenses for the remainder of the plan year. *Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).*

Partial/Day Hospitalization
This is a mental health/substance abuse benefit provided by BCBSGa. Under this benefit, a member may receive treatment sessions that are typically provided three to five times a week. Treatment sessions may be held during day or evening hours. Sessions generally last no longer than four (4) hours.

PHI (Personal Health Information)
Personal health information, which is protected from unauthorized disclosure by Board of Regents, by state statute, and by federal law, is referred to as “protected health information,” or “PHI.” PHI is defined as any individually identifiable health information regarding the medical/dental history, the mental or physical condition, or the medical treatment of an employee, a student, or a patient. Examples of PHI include patient name, address, telephone and/or fax number, electronic mail address, social security number or other patient identification number, date of birth, date of treatment, medical treatment records, medical enrollment records, or medical claims records.

Point of Service (POS)
A *Point of Service (POS)* is a comprehensive network of doctors, hospitals, and ancillary providers that have agreed to offer quality medical treatment, services and care at discounted rates. A member will receive the highest level of benefit coverage when using an in-network provider. A member may use an out-of-network provider, but he/she will receive a lower level of benefit coverage.

Provider
A *provider* is a licensed medical doctor, a plan-approved healthcare professional, and/or a hospital/medical facility.

Service Area
A *service area* consists of approved counties and geographic areas in which network services are available.
Disclaimer:
This booklet summarizes your POS healthcare plan. It is not intended to cover all the details of the POS healthcare plan. This booklet is not a contract and the benefits that are described can be terminated or amended by the University System of Georgia in its sole discretion. Should any questions arise, the master contract and the contract of the administration are the final authorities in determining benefits.

LEGISLATION PASSED BY THE 2008 GEORGIA GENERAL ASSEMBLY AND SIGNED BY THE GOVERNOR

There was no legislation passed by the 2008 session of the Georgia General Assembly that will impact the Board of Regents POS Health Benefits Plan Summary Document.

Disclaimer:
This information is provided for informational purposes only and no warranty is provided for accuracy. Members should consult legal counsel regarding legal rights and responsibilities.

Revised 7-08

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Mental Health Parity and Addiction Equity Act
The Mental Health Parity and Addiction Equity Act provides for parity in the application of mental health and substance abuse benefits with medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set benefits that are lower than benefits for medical and surgical benefits. The Plan may not impose Deductibles, 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 Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the Summary of Benefits.

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

Choice of Primary Care Physician
The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator’s Network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification card or refer to the Claims Administrator’s website, www.bcbsga.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care
You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to the Claims Administrator’s website, www.bcbsga.com.