

**BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF  
GEORGIA, INC.**

**BCBSHP Bronze Blue OpenAccess POS 10% for HSA  
Member Contract**



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## Individual Member Contract

### Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.

**3350 Peachtree Road, N.E., P.O. Box 4445, Atlanta, GA 30302**

We want You to understand the terms of this Contract. As You read through it, remember "We", "Us" and "Our" refer to Blue Cross Blue Shield Healthcare Plan of Georgia. We use the words "You" and "Your" to mean each covered Member.

**Capitalized Terms** - Capitalized terms such as Covered Services, Medically Necessary, Network Provider and Out-of-Pocket Limit are defined in the "Definitions" section.

**Refund Upon Examination** – If this Contract is provided to You as a new Subscriber, You have 10 days to read this Contract. If You change Your mind and decide You do not want this Contract, You may return it, along with a written request for cancellation within 10 days from the receipt of this Contract and any Premiums which You have paid will be returned to You. At that time, You will have no further obligation. This Contract explains the benefits payable. Remember, if You decide You do not want the Contract, We will not cover any claims You may have during the 10-day period.

Blue Cross Blue Shield Healthcare Plan of Georgia (called "BCBSHP" in this Contract) agrees to provide coverage for You and any Members of Your family who are enrolled. (BCBSHP will notify You if any Member of Your family is not eligible.) Your coverage is based on the information on Your Application for Coverage and on Your payment of Premiums to BCBSHP. The amount of money paid on Your claims is based on the terms of this Contract.

The Effective Date of this Contract is the date assigned by BCBSHP. After Your first payment to BCBSHP (called "Premiums"), the Contract shall be in force until Your next payment is due. All payments except the first, have a grace period which is explained in more detail in another section called "When Your Coverage Terminates". Please note, however, that You are not covered until BCBSHP receives Your first payment and You are approved for coverage by Us. All payments after the first one must be paid **on or before** the date they are due (BCBSHP calls this date the "**due date**").

**How to Get Language Assistance** - BCBSHP is committed to communicating with our Members about their health plan, no matter what their language is. BCBSHP employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of Your Identification Card and a representative will be able to help You. Translation of written materials about Your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with Your needs.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling the Customer Service number.)

This Contract is issued in the State of Georgia and governed by the laws of that state.

**Blue Cross Blue Shield Healthcare Plan of Georgia**



**C. Morgan Kendrick**  
**President**

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## Member Rights And Responsibilities

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As a Member, You have rights and responsibilities when getting health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. That means giving You access to Our Network of health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

### **You have the right to:**

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your plan.
- Work with Your Doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect Us to keep Your personal health information private by following Our privacy policies and state and Federal laws.
- Get information You need to help make sure You get the most from Your health plan, and share Your feedback. This includes information on:
  1. Our company and services.
  2. Our Network of health care Providers.
  3. Your rights and responsibilities.
  4. The rules of Your health plan.
  5. The way Your health plan works.
- Make a complaint or file an appeal about:
  1. Your health plan and any care You get.
  2. Any Covered Service or benefit ruling that Your health care plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what result from it. You can ask for help if You do not understand this information.

### **You have the responsibility to:**

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health plan rules and policies.
- Choose a Network primary care Physician, also called a PCP, if Your health plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You have may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the care plan that You have agreed on with Your health care Providers.
- Give Us, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health plan. This may include information about other health coverage and insurance benefits You have along with Your coverage with Us.
- Inform Customer Service if You have any changes to Your name, address or family members covered under Your plan.

If You would like more information, have comments, or would like to contact Us, please go to [bcbsga.com](http://bcbsga.com) and select Customer Support>Contact Us. Or call the Customer Services number on Your ID card.

We want to provide high quality benefits and customer service to Our Members. Benefits and coverage for services given under the plan are overseen by the Contract, Member Handbook or Schedule of Benefits and Cost Shares and not by this Member Rights and Responsibilities statement.

# Table of Contents

<b>SCHEDULE OF COST SHARES &amp; BENEFITS</b> .....	1
<b>How Your Benefits Work For You</b> .....	9
Network Services and Benefits.....	9
How to Find a Provider in the Network.....	10
Hospital Inpatient Benefits.....	11
Inter-Plan Arrangements.....	12
<b>Requesting Approval for Benefits</b> .....	15
<b>Benefits</b> .....	19
<b>Limitations and Exclusions</b> .....	49
<b>Claims and Payments</b> .....	62
Hospital Services.....	62
Physician Services.....	62
Other Services or Supplies.....	62
Maximum Allowed Amount.....	63
<b>Appeals and Complaints</b> .....	67
Contract Administration.....	67
Time of Payment of Claims.....	67
Questions About Coverage or Claims.....	68
Explanation of Benefits.....	68
Summary of Grievances.....	69
Right to Receive Necessary Information.....	69
Unauthorized Use of Identification Card; Fraudulent Statements.....	69
<b>Eligibility and Enrollment</b> .....	70
<b>When Your Coverage Terminates</b> .....	74
Termination of the Member.....	74
Effective Dates of Termination .....	74
Guaranteed Renewable .....	74
Loss of Eligibility .....	75
Rescission .....	75
Discontinuation of Health Coverage .....	75
After Termination.....	75
Grace Period.....	75
Removal of Members .....	75
Refund of Premium.....	75
<b>General Provisions</b> .....	76
Entire Contract and Changes.....	76
Change Notification - Members.....	76
Change Notification - Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.....	76
Physical Examinations.....	77
Legal Action.....	77
Assignment of Benefits.....	77
Unreasonable Fees.....	77
Compliance with Given Provisions.....	77
Unpaid Premium.....	77
Applicable Law.....	78
Care Received Outside the United States.....	78
Licensed Controlled Affiliate.....	78
Voluntary Clinical Quality Programs.....	78
Medical Policy and Technology Assessment.....	78
<b>Definitions</b> .....	80

# SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of Your benefits for Covered Services, which are listed in detail in the “Benefits” section. A list of services that are not covered can be found in the “Limitations and Exclusions” section.

**Services will only be Covered Services if rendered by Providers located in the state of Georgia unless:**

- The services are for Emergency Care, Urgent Care and ambulance services; or**
- The services are approved in advance by Anthem.**

## What will I pay?

This chart shows the most You pay for Deductibles and Out-of-Pocket expenses for Covered Services in one year of coverage.

The Deductible applies to all Covered Services with a Copayment and/or Coinsurance, including 0% Coinsurance, except for:

- Network Preventive Care Services required by law
- Pediatric Vision Services
- Services, listed in the chart below, that specifically indicate that the Deductible does not apply

## Plan Features

Deductible	In-Network Member Pays	Out-of-Network Member Pays
<b>Individual</b>	\$6,000	\$18,000
<b>Family</b>	\$12,000	\$36,000
<p>The individual Deductible applies to each covered family member. No one person can contribute more than their individual Deductible amount.</p> <p>Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that calendar year.</p>		

Coinsurance	In-Network Member Pays	Out-of-Network Member Pays
<b>Coinsurance Percentage</b> (unless otherwise specified)	10% Coinsurance	40% Coinsurance

Out-of-Pocket Limit	In-Network Member Pays	Out-of-Network Member Pays
<b>Individual</b>	\$6,550	\$19,650
<b>Family</b> Includes Deductible, Copayments and Coinsurance	\$13,100	\$39,300

Out-of-Pocket Limit	In-Network Member Pays	Out-of-Network Member Pays
<p>The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that calendar year. No one person can contribute more than their individual Out-of-Pocket Limit.</p>		

**Medical Services**

Medical Services	Network Member Pays	Out-of-Network Member Pays
<p><b>Allergy Injections</b></p>	<p>\$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance</p>
<p><b>Ambulance Services</b></p> <p><b>Emergency</b></p> <p><b>Non-Emergency</b> Benefits for non-Emergency ambulance services will be limited to \$50,000 per occurrence if an Out-of-Network Provider is used.</p>	<p>\$0 Copayment 10% Coinsurance \$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 10% Coinsurance \$0 Copayment 40% Coinsurance</p>
<p><b>Autism Services</b></p> <p><b>Applied Behavior Analysis</b> Limited to a maximum of \$30,000 Network and Out-of-Network combined per Benefit Period for Members through age six.</p> <p><b>All other Covered Services for Autism</b></p>	<p>\$0 Copayment 10% Coinsurance \$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance \$0 Copayment 40% Coinsurance</p>
<p><b>Dental Services</b> (only when related to accidental injury or for certain Members requiring general anesthesia)</p>	<p>Copayment/Coinsurance determined by service rendered</p>	
<p><b>Diabetic Management Program</b></p>	<p>\$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance</p>

Medical Services	Network Member Pays	Out-of-Network Member Pays
<b>Diabetic Medical Equipment &amp; Supplies</b>	Copayment/Coinsurance determined by service rendered	
<b>Diagnostic Services; Outpatient</b>		
<b>Diagnostic Laboratory and Pathology Services</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Diagnostic Imaging Services and Electronic Diagnostic Tests</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Advanced Imaging Services</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Doctor Office Visits</b>		
<b>Primary Care Physician (PCP) Office Visits</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Specialty Care Physician (SCP) Office Visits</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Other Office Services</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Durable Medical Equipment (medical supplies and equipment)</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Emergency Room Visits</b> (Copayment is waived if admitted to the Hospital)	\$350 Copayment 10% Coinsurance	\$350 Copayment 10% Coinsurance
<b>Home Health Care</b> Limited to a maximum of 120 visits per Member, per calendar year.	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Hospice Care</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Hospital Services</b>		
<b>Inpatient</b>	\$0 Copayment per Admission 10% Coinsurance	\$0 Copayment 40% Coinsurance



Medical Services	Network Member Pays	Out-of-Network Member Pays
<p><b>Outpatient</b></p> <p><b>Inpatient and Outpatient Professional Services</b></p>	<p>\$0 Copayment 10% Coinsurance</p> <p>\$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance</p> <p>\$0 Copayment 40% Coinsurance</p>
<p><b>Mental Health &amp; Substance Abuse</b></p> <p><b>Inpatient Admission</b></p> <p><b>Outpatient Facility</b></p> <p><b>Outpatient Office Visit</b></p>	<p>\$0 Copayment per Admission 10% Coinsurance</p> <p>\$0 Copayment 10% Coinsurance</p> <p>\$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance</p> <p>\$0 Copayment 40% Coinsurance</p> <p>\$0 Copayment 40% Coinsurance</p>
<p><b>Outpatient Therapy Services</b></p> <p>Chemotherapy and radiation</p> <p>Respiratory 20 visits per Member per calendar year</p> <p>Chiropractic 20 visits per Member per calendar year</p> <p>Occupational and physical therapy combined 20 visits each per Member per calendar year</p> <p>Speech therapy 20 visits per Member per calendar year</p> <p>Cardiac Rehabilitation 20 visits per Member per calendar year</p> <p>Therapy visit limits do not apply to autism services.</p>	<p>\$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance</p>
<p><b>Preventive Care Services</b></p> <p>Network services required by law are not subject to Deductible.</p>	<p>\$0 Copayment 0% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance</p>
<p><b>Prosthetics – prosthetic devices, their repair, fitting, replacement and components</b></p>	<p>\$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance</p>
<p><b>Skilled Nursing Facility</b></p> <p>Limited to a maximum of 30 days per Member, per calendar year</p>	<p>\$0 Copayment 10% Coinsurance</p>	<p>\$0 Copayment 40% Coinsurance</p>

Medical Services	Network Member Pays	Out-of-Network Member Pays
<b>Surgery</b> <b>Inpatient Admission</b>  <b>Outpatient Treatment</b>  <b>Ambulatory Surgical Center</b>	\$0 Copayment per Admission 10% Coinsurance  \$0 Copayment 10% Coinsurance  \$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance  \$0 Copayment 40% Coinsurance  \$0 Copayment 40% Coinsurance
<b>Temporomandibular and Craniomandibular Joint Treatment</b>	Copayment/Coinsurance determined by service rendered	
<b>Transplant Human Organ &amp; Tissue</b> In-Network only - Transplant Transportation and Lodging \$10,000 maximum benefit limit per transplant Unrelated Donor Search - \$30,000 maximum benefit limit per transplant	Copayment/Coinsurance determined by service rendered	
<b>Urgent Care Center</b>	\$50 Copayment 10% Coinsurance	\$50 Copayment 10% Coinsurance

**Prescription Drugs**

<b>Retail Pharmacy Prescription Drugs</b> (30-day supply per prescription)	<b>Network Member Pays</b>	<b>Out-of-Network Member Pays</b>
<b>Tier 1</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Tier 2</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Tier 3</b>	\$0 Copayment 10% Coinsurance	\$0 Copayment 40% Coinsurance
<b>Tier 4</b> Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	\$0 Copayment 10% Coinsurance	Not Covered

<b>Mail Order Prescription Drugs</b>	<b>Network Member Pays</b>	<b>Out-of-Network Member Pays</b>
<b>Tier 1</b> (90-day supply)	\$0 Copayment 10% Coinsurance	Not Covered
<b>Tier 2</b> (90-day supply)	\$0 Copayment 10% Coinsurance	Not Covered
<b>Tier 3</b> (90-day supply)	\$0 Copayment 10% Coinsurance	Not Covered
<b>Tier 4</b> (30-day supply) Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	\$0 Copayment 10% Coinsurance	Not Covered
<b>Orally Administered Cancer Chemotherapy</b>	As required by Georgia law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	

**Pediatric Dental Services**

We cover the following dental care services for members to the end of the month in which they turn age 19. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this “Schedule of Cost-Shares and Benefits.” Please see “Dental Services – Dental Care for Pediatric Members” in the “Benefits” section of this Contract for a detailed description of services.

<b>Pediatric Dental Care</b>	<b>Network Member Pays</b>	<b>Out-of-Network Member Pays</b>
<b>Diagnostic and Preventive Services</b>	10% Coinsurance	10% Coinsurance
<b>Basic Restorative Services</b>	40% Coinsurance	40% Coinsurance
<b>Oral Surgery Services</b>	50% Coinsurance	50% Coinsurance
<b>Endodontic Services</b>	50% Coinsurance	50% Coinsurance
<b>Periodontal Services</b>	50% Coinsurance	50% Coinsurance
<b>Major Restorative Services</b>	50% Coinsurance	50% Coinsurance
<b>Prosthodontic Services</b>	50% Coinsurance	50% Coinsurance
<b>Dentally Necessary Orthodontic Care Services</b> Subject to a 12-month waiting period	50% Coinsurance	50% Coinsurance

### Pediatric Vision Services

The following benefits are available to Members through the end of the month in which they turn 19. Coverage is only provided when services are received from a Blue View Vision Provider. If You need help finding a Blue View Vision provider, please visit Our website or call the number on Your ID Card. Out of Network Providers may bill you for any charges that exceed the plan's Maximum Allowed Amount.

These vision services do not apply to the medical Deductible.

Pediatric Vision Care	Network Member Pays	Out-of-Network Payment Reimbursement
<b>Routine Eye Exam</b> Once every Calendar Year	\$0 Copayment	\$30 Reimbursement
<b>Standard Plastic Lenses*</b> Once every Calendar Year		
<b>Single Vision</b>	\$0 Copayment	\$25 Reimbursement
<b>Bifocal</b>	\$0 Copayment	\$40 Reimbursement
<b>Trifocal</b>	\$0 Copayment	\$55 Reimbursement
<b>Progressive</b>	\$0 Copayment	\$40 Reimbursement
Lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic lenses at no additional cost when received In-Network.		
<b>Frames*(formulary)</b> This Plan offers a selection of covered frames. Once every Calendar Year	\$0 Copayment	\$45 Reimbursement
<b>Contact Lenses*(formulary)</b> This Plan offers a selection of covered contact lenses. One every Calendar Year		
<b>Elective</b> (conventional and disposable)	\$0 Copayment	\$60 Reimbursement
<b>Non-Elective</b>	\$0 Copayment	\$210 Reimbursement

\*If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed.

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## How Your Benefits Work For You

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### Network Services and Benefits

If Your care is rendered by a Primary Care Physician, Specialty Care Physician, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a Primary Care Physician, Specialty Care Physician, or another Network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other facility. This decision is made upon review of Your condition and treatment. You may appeal this decision. See the “Appeals and Complaints” section of this Contract.

**Network Providers** include Primary Care Physicians, Specialty Care Physicians, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for You. Primary Care Physicians include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange Your health care services.

Specialty Care Physicians are Network Physicians who provide specialty medical services not normally provided by a Primary Care Physician.

A consultation with a Network health care Provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

For services rendered by Network Providers:

- You will not be required to file any claims for services You obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Copayments/Coinsurance and/or Deductibles. You may be billed by Your Network Provider(s) for any non-Covered Services You receive or where You have not acted in accordance with this Contract.
- Health Care Management is the responsibility of the Network Provider.

If there is no Network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an authorized service. Non-Network Providers are described below.

### Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an authorized service will be considered a Non-Network service. The only exceptions are Emergency Care, urgent care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see the “Schedule of Cost-Shares and Benefits.”

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

BCBSHP has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services

authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

## How to Find a Provider in the Network

There are three ways You can find out if a Provider or facility is in the Network for this plan. You can also find out where they are located and details about their license or training.

- See Your plan's directory of Network Providers at [www.bcbsga.com](http://www.bcbsga.com), which lists the Doctors, Providers, and facilities that participate in this plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this plan's Network, based on specialty and geographic area.
- Check with Your Doctor or Provider.

If You need details about a Provider's license or training, or help choosing a Doctor who is right for You, call the Customer Service number on the back of Your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with Your needs.

### First - Make an Office Visit with Your Primary Care Physician

Your Primary Care Physician's job is to help You stay healthy, not just treat You when You are sick. After You pick a Primary Care Physician set up an office visit. During this visit, get to know Your Primary Care Physician and help Your Primary Care Physician get to know You. You should talk to Your Primary Care Physician about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns You have.

If You do not get to know Your Primary Care Physician, they may not be able to properly manage Your care. To see a Doctor, call their office:

- Tell them You are an BCBSHP Member,
- Have Your Member Identification Card handy. The Doctor's office may ask You for Your group or Member ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Member Identification Card with You.

If You need to see a Specialist, You can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If You have any questions about Covered Services, call Us at the telephone number listed on the back of Your Identification Card.

## Relationship of Parties (BCBSHP and Network Providers)

The relationship between BCBSHP and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of Ours, nor is BCBSHP, or any employee of BCBSHP, an employee or agent of Network Providers.

Your health care Provider is solely responsible for all decisions regarding Your care and treatment, regardless of whether such care and treatment is a Covered Service under this plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any Network Provider or for any injuries suffered by You while receiving care from any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including Network Providers, Out-of-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or Us.

## **Payment Innovation Programs**

We pay Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) - may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by Us from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to Us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Health Care Services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by Us or to Us under the Program(s), and You do not share in any payments made by Network Providers to Us under the Program(s).

## **Hospital Inpatient Benefits**

Hospital Inpatient benefits are available only if a Member is admitted as a bed patient to a Hospital on the order of a licensed Physician. The Member must be under the care of this Physician. The Physician must be on the staff of, or acceptable to, the Hospital at which the Member is a patient.

The service which the Member gets at a Hospital is subject to all the rules and regulations of the Hospital selected. Such rules also control admission policies.

You can choose any legally constituted and approved Hospital You like for the care You receive; however, Your out-of-pocket expenses are higher when You receive care from Non-Network Providers. BCBSHP does not guarantee Your Admission to any Hospital. Also, BCBSHP does not guarantee that any particular service or type of room will be available even if requested by Your Physician.



## Special Requirements

1. Special Requirements for Hospital Admission and continued stay:
  - a. The care must be consistent with the diagnosis, illness or Injury.
  - b. The condition must require treatment in a Hospital.
  - c. The Admission or stay must be Medically Necessary.
  - d. If You are confined in a Hospital, Substance Abuse treatment facility, or Skilled Nursing Facility when Your insurance would otherwise have started, Your Effective Date is:
    - i. the date You are discharged; or
    - ii. if You are covered by another insurance policy, the date the other insurance policy stops paying benefits.
2. Special requirements for medical and surgical care:
  - a. The treatment will be Medically Necessary.
  - b. The treatment must have been on or after the Effective Date of Your Contract.
  - c. Services must be performed or prescribed by a Physician except for certain services performed by other covered health care Providers as described in this Contract.

## Inter-Plan Arrangements

### Out-of-Area Services

BCBSHP covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the BCBSHP Service Area is always covered. For those out-of-area healthcare services that BCBSHP does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee (“Host Blue”) with which BCBSHP has a relationship (referred to as an “Inter-Plan Program”), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to BCBSHP for payment in accordance with the then current rules that apply to these Programs. These programs include the BlueCard® Program, which is described in general terms below.

### BlueCard® Program

Under the BlueCard Program, when You obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, BCBSHP will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its Participating Providers; and (b) handling interactions with those Providers.

The BlueCard Program allows You to obtain out-of-area covered services and supplies from a healthcare Provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for those Covered Services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment, Coinsurance and/or Deductible stated in this Contract.

Whenever You obtain covered services or supplies outside BCBSHP Service Area and the claim is processed through the BlueCard Program, the amount You pay for them, if not a Copayment, is calculated based on the lower of:

- The billed covered charges for the Covered Services or supplies; or
- The negotiated price that the Host Blue makes available to BCBSHP.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted

above. But such adjustments will not affect any price that BCBSHP has already paid for Your claim or Your liability for any such claim.

Also, federal law in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, BCBSHP would then calculate Your liability for any Covered Service or supply according to applicable law.

### **Non-Participating Healthcare Providers Outside the Service Area**

As mentioned under “Out-of-Area Services” above, BCBSHP only covers limited healthcare services outside of its Service Area. If You need to go to a Non-Participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of Non-Participating, out-of-area Providers are covered, the amount that You pay for the provided services, if not a Copayment, will generally be based on either the Host Blue’s local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, BCBSHP may pay claims from Non-Participating Providers outside of BCBSHP’s Service Area based on the Provider’s billed charge. For example, this could happen in a case where You did not have reasonable access to a Participating Provider, as determined by BCBSHP or in accordance with applicable state law. In other cases, BCBSHP may pay such a claim based on the payment We would make if We were paying a Non-Participating Provider inside of Our Service Area. This could happen when the Host Blue’s payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

## **Travel outside the United States – BlueCard Worldwide**

If You plan to travel outside the United States, call Customer Service to find out if Your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with You.

### **When You are traveling abroad and need medical care**

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or You can call them collect at 1-804-673-1177. An Assistance Coordinator will speak with You and help to set up an appointment with a Doctor or Hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for You.

If You need Inpatient Hospital care, You or someone on Your behalf, should contact Us for Preauthorization. Keep in mind, if You need emergency medical care, go to the nearest Hospital. There is no need to call before You receive care. Please refer to the “Requesting Approval for Benefits” section where You can learn how to get Preauthorization when You need to be admitted to the Hospital for emergency care.

### **How claims are paid with BlueCard Worldwide**

In most cases, when You arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating Hospital, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors’ services;
- Inpatient Hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

**When You need BlueCard Worldwide claim forms**

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide).

You will find the address for mailing the claim on the form.

**Notification**

If You are admitted to the Hospital as a result of an emergency, You, or a family member or friend, must notify BCBSHP within 48 hours by calling 1-800-722-6614. This will allow Your Physician to consult with the Physician providing Your care and to coordinate further medical care when necessary. By notifying Us as soon as possible, You will protect Yourself from potential liability for payment for services You receive after transfer would have been possible. We will only cover care required for stabilization and before Your medical condition permits Your travel or transfer to another facility We designate.

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## Requesting Approval for Benefits

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### Requesting Approval for Benefits

Your plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by Your plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to You in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for You to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and Pharmacy and therapeutics guidelines. BCBSHP may decide that a service that was prescribed or asked for is not Medically Necessary if You have not first tried other Medically Necessary and more cost effective treatments.

If You have any questions about the information in this section, You may call the Customer Service phone number on the back of Your Identification Card.

#### Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency Admissions, You, Your authorized representative or Doctor must tell us within 48 hours of the Admission or as soon as possible within a reasonable period of time. For labor/childbirth Admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check Your Contract to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract or is Experimental/Investigative as that term is defined in this Contract.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or Admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review (“requesting Provider”). We will work with the requesting Provider for the Precertification request. However, You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services provided by a Network Provider	Services provided by a BlueCard/Out-of-Network/Non-Participating Provider
Provider	<ul style="list-style-type: none"> <li>Member must get Precertification.</li> <li>If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part.</li> <li>For Emergency admissions, You, Your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.</li> </ul>

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any medically necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigational as that term is defined in the plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

BCBSHP may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in BCBSHP's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt Your claim from medical review if certain conditions apply.

Just because BCBSHP exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that BCBSHP will do so in the future, or will do so in the future for any other Provider, claim or Insured. BCBSHP may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking Your on-line Provider Directory on-line Precertification list or contacting Customer Service at the number on Your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to plan's members.

**Request Categories**

- Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of Your medical condition, could without such care or treatment, seriously threaten Your life or health or Your ability to regain maximum function or subject You to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

**Decision and Notification Requirements**

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If You live in and/or get services in a state other than the state where Your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Urgent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review urgent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to You or Your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information we have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

**Verbal:** Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

**Written:** Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and You or Your authorized representative.

**Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date You get service:**

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a covered benefit under Your plan;
4. The service cannot be subject to an Exclusion under Your plan; and
5. You must not have exceeded any applicable limits under Your plan.

### **Health Plan Individual Case Management**

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Care Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to You. These programs are provided by, or on behalf of and at the request of, Your health plan case management staff. These Case Management programs are separate from any Covered Services You are receiving.

If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your chosen representative, treating Doctor(s), and other Providers.

In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs. This may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and BCBSHP. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

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## Benefits

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Please refer to the “Schedule of Cost Shares and Benefits” for additional benefit information.

### Payment Terms

Payment terms apply to all Covered Services. The following services are applicable to Network and Non-Network benefits. All Covered Services must be Medically Necessary.

### Physician Services

You may receive treatment from a Network Physician. Such services are subject to any applicable Deductible and Out-of-Pocket requirements.

If You need care after normal business hours, Your Doctor may have several options for You. You should call Your Doctor’s office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest emergency room.

### Preventive Care under Health Care Reform

Under the Patient Protection and Affordable Care Act (PPAC), many preventive care services are covered by this policy with no Cost Sharing required from the covered person. These services fall under four broad categories shown below.

Your policy covers many preventive care benefits with no cost sharing required from You. That means We pay 100% of the allowable charge.

Here are the broad categories of benefit requirements that are covered with no Cost Sharing – meaning, no Deductible, no Coinsurance and/or no Copayments - from the covered person:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force;
2. Immunizations from the most current version of Recommendations of the Advisory Committee on Immunization Practices;
3. Infants, children and adolescents’ preventive care and screenings supported by Health Resources comprehensive guidelines; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - a. Women’s contraceptives, sterilization procedures, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the Prescription Drug benefit.
  - b. Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Durable Medical Equipment (DME) supplier. If another Provider is used, benefits will be covered as Non-Network. Benefits for breast pumps are limited to one per calendar year or as required by law.
  - c. Gestational diabetes screening.

You may call Customer Service using the number on Your ID card for additional information about these services. You may also visit the federal government websites:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>  
<http://www.ahrq.gov>  
<http://www.cdc.gov/vaccines/acip/index.html>



## Preventive Services

### Mammograms, Cervical Cancer Examinations, Prostate Antigen Tests and Chlamydia Screening Tests

Your Contract covers wellness and preventive services as outlined in Your “Schedule of Cost Shares and Benefits”, including screenings, immunizations and other services to detect medical conditions in advance. Preventive and wellness services are covered as recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics, and for childhood immunizations, as prescribed by the Commissioner of Health.

Sometimes during the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and Your Provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by Your Provider. If any of the services are considered diagnostic and/or surgical, rather than screening, then Your Deductible (if any) and/or Coinsurance will apply.

In addition to the office visits that accompany these services, the following screening tests are included but not limited to:

1. Benefits are provided for mammograms and the related office visit when provided by an eligible Provider.
2. Benefits will be provided for cervical cancer tissue examinations per year, or when performed upon recommendation of a Physician.
3. Benefits will be provided for annual prostate specific antigen tests and the related office visits for covered males.
4. Benefits are provided for one annual Chlamydia screening test and the related office visit for covered females.

Coverage for the following immunizations is also included (but not limited to), in accordance with the recommendations of the previously mentioned organizations:

- Hepatitis A;
- Hepatitis B;
- Influenza (flu shot);
- Pneumococcal conjugate (pneumonia);
- Human papilloma virus (HPV);
- H. Influenza type b as appropriate for infants and children;
- Polio as appropriate for infants and children;
- Measles, mumps, rubella (MMR).

Some immunizations are covered when administered by a licensed pharmacist who is authorized by a Physician to perform this service. To determine whether or not a licensed pharmacist is authorized to perform this service, You may ask the licensed pharmacist.

**LIMITATION:** This routine care benefit cannot be used for vision care, hearing care or dental care. Coverage for routine care is subject to the exclusions of this Contract.

## Child Wellness Services

Benefits are provided for child wellness services from birth through age five. These services are not subject to the calendar year Deductible. Covered Services are based on the standards for preventive pediatric health care published by the American Academy of Pediatrics. Child wellness services include:

- Periodic Health Assessments (includes a medical history and appropriate physical exam);
- Developmental assessment of the child;

- Age appropriate immunizations;
- Laboratory testing.

## **Inpatient Hospital Services**

Your Contract provides Covered Services when the following services are Medically Necessary.

### **Network Inpatient Hospital Benefits**

If You are admitted to the Hospital, Your coverage provides benefits for Inpatient care. This includes charges for Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, eligible charges are based on the Hospital's prevalent Semiprivate Room rate. If You are admitted to a Hospital that has only private rooms, eligible charges are based on the Hospital's prevalent room rate.

Your benefits Cover Services and supplies provided and billed by the Hospital while You are an Inpatient, including the use of operating and recovery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, radiation therapy, speech therapy and occupational therapy are also covered.

Convenience items (such as radios, TV's, record and CD players, telephone, visitors' meals, etc.) are not covered.

Length of stay is 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 laboratory services.

## **Outpatient Diagnostic Services**

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

### **Diagnostic Laboratory and Pathology Services**

#### **Diagnostic Imaging Services and Electronic Diagnostic Tests**

- X-rays/regular imaging services;
- Ultrasound;
- Electrocardiograms (EKG);
- Electroencephalography (EEG);
- Echocardiograms;
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care);
- Tests ordered before a surgery or admission.

### **Advanced Imaging Services**

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan;
- CTA scan;
- Magnetic Resonance Imaging (MRI);
- Magnetic Resonance Angiography (MRA);
- Magnetic resonance spectroscopy (MRS);
- Nuclear Cardiology;
- PET scans;
- PET/CT Fusion scans;

- QTC Bone Densitometry;
- Diagnostic CT Colonography.

The list of advanced imaging services may change as medical technologies change.

### **Outpatient Pre-Certification Requirements**

Your Contract provides Covered Services when outpatient services are Medically Necessary. Certain outpatient procedures require Precertification from BCBSHP. This outpatient Precertification is a requirement for Network benefits if applicable.

Such services include, but are not limited to, outpatient surgical procedures, diagnostic imaging procedures, laboratory services, pathology services and Durable Medical Equipment. This list is subject to change. Please call Customer Service at the number on Your ID card to determine if a particular procedure requires Precertification.

LIMITATION: We do not cover diagnostic services not rendered for a specific symptom to diagnose a definite condition, disease, illness, Injury or pregnancy related condition (except as listed in the Preventive Services provision of this article).

## **Emergency Room Care: Life-threatening Medical Emergency or Serious Accidental Injury**

Coverage is provided for Hospital emergency room care or treatment for initial services rendered for the onset of symptoms for a Medical Emergency of 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. In the event of an emergency call 911.

Copayment and Coinsurance may be required for care. See Your "Schedule of Cost Shares and Benefits."

## **Maternity Care**

Benefits will be provided for Hospital and Physician services are subject to Your Contract's applicable Deductible and percentage payable provisions as stated in the "Schedule of Cost Shares and Benefits."

Maternity Care is available to the female Subscriber, female covered Dependent child and/or the female covered spouse or Domestic Partner of the Subscriber. The female Subscriber or the female covered spouse or Domestic Partner of the Subscriber must also be at least 18 years of age or an emancipated minor.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are not 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 coverage for a newborn).

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 Network Physician. Should the Member (mother or child) 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 Physician.

**Note:** Abortions are covered only in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed);

### Complications of Pregnancy

Complications of pregnancy includes conditions that would be considered life threatening to the mother. A life-threatening condition would be a condition of sufficient severity that the absence of immediate medical attention could be reasonable expected to result in a threat to life (immediate or delayed).

Complications of Pregnancy include conditions where the diagnosis is distinct from the pregnancy, and are caused by or adversely affected by the pregnancy. Complications of Pregnancy do not include the actual delivery of the baby except in cases of life-threatening hemorrhage to the mother.

Examples of conditions that may be caused by or adversely affected by the pregnancy include:

- Miscarriage;
- Gestational diabetes;
- Acute nephritis and nephrosis;
- Preeclampsia;
- Cardiac decompensation;
- Ectopic pregnancy;
- Hyperemesis gravidarum; or
- Severe toxemias, with or without convulsions.

**LIMITATIONS:** Complications of Pregnancy do not include:

- Normal usual services including delivery even when a covered Complication of Pregnancy exists, except as noted above;
- Elective or non-elective cesarean section;
- High-risk pregnancy or disease;
- False labor;
- Premature labor;
- Occasional spotting;
- Physician prescribed rest;
- Morning sickness;
- Backaches;
- Fluid retention;
- Indigestion; or
- Any complication when the pregnancy began before the Effective Date of this Contract.

## Prescription Drugs

### Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third or fourth “tier” Drug. Refer to Your “Schedule of Cost Shares and Benefits” section to determine Your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

**Note:** Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by BCBSHP’s designated Pharmacy benefits manager from Drug manufacturers,

wholesalers, distributors, and/or similar vendors and/or funds received by BCBSHP from BCBSHP's designated Pharmacy benefits manager.

### **Prescription Drug List**

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If You have a question regarding whether a Drug is on the Prescription Drug Formulary, please contact the Customer Service telephone number on the back of Your Identification Card.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., oral, injected, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Benefit Program limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other BCBSHP products. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug list. Generally, it includes select Generic Drugs with limited brand Prescription Drugs Coverage. This list is subject to periodic review and modification by BCBSHP. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at [www.bcbsga.com](http://www.bcbsga.com).

### **Exception Request for a Drug not on the Prescription Drug List**

If You or Your Doctor believe You need a Prescription Drug that is not on the Prescription Drug List, please have Your Doctor or pharmacist get in touch with Us. We will cover the other Prescription Drug only if We agree that it is Medically Necessary and appropriate over the other Drugs that are on the List. We will make a coverage decision within 72 hours of receiving Your request. If We approve the coverage of the Drug, coverage of the Drug will be provided for the duration of Your prescription, including refills. If We deny coverage of the Drug, You have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving Your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of Your prescription, including refills.

You or Your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function, or if You are undergoing a current course of treatment using a drug not covered by the plan. We will make a coverage decision within 24 hours of receiving Your request. If We approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If We deny coverage of the Drug, You have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 hours of receiving Your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

Coverage of a Drug approved as a result of Your request or Your Doctor's request for an exception will only be provided if You are a Member enrolled under the plan.

### **Covered Prescription Drugs**

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and You must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-Administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-Administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details; and
- Flu Shots (including administration).

### **Retail or Home Delivery (Mail Order) Pharmacy**

Your benefit program includes benefits for Prescription Drugs You get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from Your Doctor and Your Identification Card and they will file Your claim for You. Refer to Your Schedule of Cost Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when You obtain Prescription Drugs. If You do not have Your Identification Card, the Pharmacy may charge You the full retail price of the Prescription and may not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

Helpful tip: Benefits for Prescription Drugs, including Specialty Drugs, which must be administered to You in a medical setting (e.g., Doctor's office, home care visit, or outpatient facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

### **Maintenance Medication - Home Delivery Pharmacy**

If You are taking a Maintenance Medication, You may get the first 30 day supply plus one additional 30 day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must contact the Home Delivery Pharmacy before the second refill and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication You get without registering Your choice each year through the Home Delivery Pharmacy. You can tell Us Your choice by phone by contact the Customer Service telephone number on the back of Your Identification Card or by visiting Our website at [www.bcbsga.com](http://www.bcbsga.com).

Your home delivery (mail order) Prescription Drug program is administered by BCBSHP's PBM which lets You get certain Drugs by mail if You take them on a regular basis. Your mail order Prescriptions are filled by an independent, licensed Pharmacy. BCBSHP does not dispense Drugs or fill Prescriptions.

Helpful Tip: If You decide to use Home Delivery Choice, We suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the mail order program, You can contact the Customer Service telephone number on the back of Your Identification Card.

The Prescription must state the dosage and Your name and address; it must be signed by Your Physician.

The first mail order Prescription You submit must include a completed patient profile form. This form will be sent to You upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program Customer Service department at the Customer Service telephone number on the back of Your Identification Card for availability of the Drug or medication.

### **Specialty Pharmacy**

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

### **When You Order Your Prescription Through the Specialty Preferred Provider**

You can only have Your Prescription for a Specialty Drug filled through the BCBSHP's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver Your specialty Drugs to You by mail or common carrier for self-administration in Your home. You cannot pick up Your medication at BCBSHP.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or Your Physician may order Your specialty Drug from the Specialty Preferred Program by calling the Customer Service telephone number on the back of Your Identification Card. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help You take charge of Your health problem and offers toll-free 24 hour access to nurses and pharmacists to answer Your questions about Specialty Drugs. A Dedicated Care Coordinator will work with You and Your Doctor to get prior authorization. When You call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide You through the process up to and including actual delivery of Your Specialty Drug to You. When You order Your Specialty Drug by telephone, You will need to use a credit or debit card to pay for it. You may also submit Your Specialty Drug Prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once You have met Your Deductible, if any, You will only have to pay the cost of Your Copayment or Coinsurance as found in the Schedule of Benefits. When You order Your Specialty Drug by mail, You will need to use a check, money order, credit or debit card to pay for it.

You or Your physician may obtain a list of Specialty Drugs available through the Specialty Preferred Provider Network by contacting Customer Service by calling the Customer Service telephone number on the back of Your Identification Card or online at [www.bcbsga.com](http://www.bcbsga.com). You or Your Physician may also obtain order forms by contacting Customer Service or by accessing Our website at [www.bcbsga.com](http://www.bcbsga.com).

### **Urgent or Emergency Need of a Specialty Drug Subject to the Specialty Pharmacy Program**

If You are out of a Specialty Drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow You to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your Doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If You order Your Specialty Drug through the Specialty Preferred Provider and it does not arrive, if Your Physician decides that it is Medically Necessary for You to have the Drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow You to get an emergency supply of medication from a Participating Pharmacy near You. A customer service representative from the Specialty Preferred Provider will coordinate the exception and You will not be required to pay additional Coinsurance.

### **Important Details About Prescription Drug Coverage**

Your Benefit Program includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day/supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when You fill a Prescription, and will be also told about any details We need to decide benefits.

### **Drug Utilization Review**

Your Prescription Drug benefits include utilization review of Prescription Drug usage for Your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify Your personal Physician and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

### **Prior Authorization**

Prior Authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact Your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both You and Your Provider.

If Prior Authorization is denied You have the right to file a Grievance as outlined in the "Appeals and Complaints" section.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of Your Identification Card or visit [www.bcbsga.com](http://www.bcbsga.com). The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Benefit Program. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or Generic Drugs are covered under the Benefit Program.

### **Step Therapy**

Step therapy is a process in which You may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.



### **Administered by a Medical Provider**

Your Benefit Program also covers Prescription Drugs when they are administered to You as part of a Doctor's visit, home care visit, or at an outpatient facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and injectables that must be administered by a Provider. This section applies when Your Provider orders the Drug and administers it to You. Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self-Administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Retail or Home Delivery (Mail Order) Pharmacy" section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Retail or Home Delivery (mail order) Pharmacy" benefit, they will not be covered under this benefit.

### **Additional Features**

#### **Day Supply and Refill Limits**

Certain day supply limits apply to Prescription Drugs as listed in the Schedule of Cost Shares and Benefits. In most cases, You must use a certain amount of Your prescription (e.g., 85%) before it can be refilled.

#### **Half-Tablet Program**

The Half-Tablet Program lets You pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets You get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells You to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and You should talk to Your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of Your Identification Card.

#### **Split Fill Dispensing Program**

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if Your Prescription Drugs or dose changes between fills, by allowing only a portion of Your prescription to be filled at a retail Pharmacy. This program also saves You out of pocket expenses.

The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free Customer Service number on Your Member ID card or log on to the Member website at [www.bcbsga.com](http://www.bcbsga.com).

### **Special Programs**

Except where prohibited by Federal regulations (such as HSA rules), from time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

### **Claims and Customer Service**

For information and assistance, a Member may call or write BCBSHP. The telephone number for Customer Service is printed on the Member's Identification Card.

The address of BCBSHP is:

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.  
Customer Service  
3350 Peachtree Road, N.E.  
Atlanta, GA 30302  
Monday through Friday - 8:00 a.m. to 5:00 p.m.

You may visit Our home office during normal business hours.

## Mental Health Care and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed residential treatment center. It offers individualized and intensive treatment and includes:
  1. Observation and assessment by a psychiatrist weekly or more often,
  2. Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when We have to cover them by law.

## Dental Services – Dental Care for Pediatric Members

All Covered Services are subject to the terms, limitations, and exclusions of Your plan. See Your “Schedule of Cost Shares and Benefits” for Your cost share amounts, such as Deductibles and/or any Coinsurance.

### Your Dental Benefits

BCBSHP does not determine whether the dental services listed in this section are Medically Necessary to treat Your specific condition or restore Your dentition. There is a preset schedule of dental care services that are covered under this plan. We evaluate the procedures submitted to Us on Your claim to determine if they are a covered service under this plan.

**EXCEPTION:** Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the “Orthodontic Treatment” section for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for Your dental condition, they may not be covered by Us. There may be an alternative dental care service available to You that is covered under Your plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, You may apply this allowance to the initial dental care service prescribed by Your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible You may have.

The decision as to what dental care treatment is best for You is solely between You and Your dentist.

### Pretreatment Estimates

A pretreatment estimate is a valuable tool for You and Your dentist. It provides You and the dentist with an idea of what Your out of pocket costs will be for the dental care treatment. This will allow the dentist and You to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthodontic, endodontic, oral surgery, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for You to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on Your current eligibility and the plan benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in Your eligibility or changes to the plan may affect Our final payment.

You can ask Your dentist to submit a pretreatment estimate for You, or You can send it to Us Yourself. Please include the procedure codes for the services to be performed (Your dentist can tell You what procedure codes). Pretreatment estimate requests can be sent to the address on Your dental ID card.

### **Dental Providers**

You do not have to select a particular dentist to receive dental benefits. You can choose any dentist You want for Your dental care. However, Your dentist choice can make a difference in what benefits are covered and how much You will pay out-of-pocket. You may have more out-of-pocket costs if You use a dentist that is a Non-Participating dentist. There may be differences in the amount We pay between a Participating dentist and a Non-Participating dentist.

Please call Our Customer Service department at the number shown on the back of Your ID card for help in finding a Participating dentist or visit Our website at [www.anthem.com/mydentalvision](http://www.anthem.com/mydentalvision). Please refer to Your ID card for the name of the dental program that Participating Providers have agreed to service when You are choosing a Participating dentist.

### **Description of Covered Services**

**We cover the following dental care services for Members to the end of the month in which they turn age 19** when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for Your dental condition, We will cover the least expensive.

### **Diagnostic and Preventive Services**

**Oral Evaluations** - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

#### **Radiographs (X-rays)**

- Bitewings - 1 series of bitewings per 6-month period for Members through age 17; 1 series per 12 months for Members age 18 and over.
- Full Mouth (Complete Series) - Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical
- Occlusal
- Extraoral

**Dental Cleaning (Prophylaxis)** – Covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth. Cleanings performed on a member under the age of 14 will be covered as a child cleaning. Cleanings performed on a member age 14 or older will be covered as an adult cleaning.

**Fluoride Treatment** (Topical application of fluoride) - Covered 2 times per calendar year.

**Fluoride Varnish** - Covered 2 times per calendar year.

**Sealants or Preventive Resin Restorations** - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

**Space Maintainers****Recement Space Maintainers**

**Emergency Treatment** for the temporary relief of pain or infection.

**Basic Restorative Services**

**Consultations** with a dentist other than the one providing treatment.

**Office Visits**

**Amalgam (silver) Restorations** - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

**Composite (white) Resin Restorations** - Treatment to restore decayed or fractured permanent or primary teeth.

- Anterior (front) teeth.
- Posterior (back) teeth. If You chose to have a composite restoration placed on a posterior (back) tooth, the benefit will be limited to the allowance for an amalgam restoration for the same surface. You must pay the difference between the plan's maximum allowed amount for the amalgam restoration and the dentist's charge for the composite restoration, plus any applicable deductible or coinsurance.

**Periodontal Maintenance** - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment. Any combination of this procedure and dental cleanings (see "Diagnostic and Preventive" section) is covered 4 times per 12-month period.

**Endodontic Therapy on Primary Teeth**

- Pulpal Therapy
- Therapeutic Pulpotomy

**Basic Non-Surgical Periodontal Care** - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per quadrant per 24 months.

**Resin based composite resin crown, anterior** - Covered 1 time per 24-month period.

**Partial Pulpotomy for apexogenesis** - Covered 1 time per lifetime on permanent teeth only.

**Pin Retention**

**Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 60-month period for eligible dependent children through the age of 14.

**Therapeutic Drug Injection****Fabrication of Athletic Mouthguard****Internal Bleaching****Endodontic Services****Endodontic Therapy on Permanent Teeth**

- Root Canal Therapy
- Root Canal Retreatment

**Other Endodontic Treatments**

- Pulpal regeneration
- Apexification

- Apicoectomy
- Root amputation
- Hemisection
- Retrograde filling

## Periodontal Services

**Basic Non-Surgical Periodontal Care** - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Full mouth debridement – Covered 1 time per lifetime.

**Crown Lengthening** – Covered 1 time per lifetime.

## Chemotherapeutic Agents

**Complex Surgical Periodontal Care** - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only.

Complex surgical periodontal services are limited as follows: Only one complex surgical periodontal service is covered per 36-month period per single permanent tooth or for multiple teeth in the same quadrant.

## Oral Surgery Services

### Basic Extractions

- Extraction of erupted tooth or exposed root.
- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth.

### Complex Surgical Extractions

- Surgical removal of erupted tooth.
- Surgical removal of impacted tooth.
- Surgical removal of residual tooth roots.

### Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

### Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue) .
- Collection and application of autologous product – Covered 1 time per 36-month period.
- Excision of pericoronal gingiva.
- Coronectomy.

- Tooth reimplantation of accidentally evulsed or displaced tooth.
- Suture of recent small wounds up to 5 cm.

### **Adjunctive General Services**

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia – Covered only when given with covered complex surgical services. This service will not be covered if performed with non-surgical dental care.

### **Major Restorative Services**

**Gold foil restorations** - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the plan's maximum allowed amount for the covered service and the dentist's submitted fee for the optional treatment, plus any deductible and/or coinsurance for the covered service.

**Inlays** - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

**Onlays and/or Permanent Crowns** - Covered once every 5-year period if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

**Implant Crowns** - See the "Prosthetic Services" section.

**Recent Inlay, Onlay, and - Crowns** Covered 6 months after initial placement.

**Crown/Inlay/Onlay Repair** - Covered 1 time per 12 month period per tooth when the submitted narrative from the treating dentist supports the procedure.

**Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface** - Covered once every 5 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

**Prefabricated post and core in addition to crown** - Covered once per tooth every 60 months.

**Occlusal guards** - Covered once every 12 months for Members age 13 through 18.

### **Prosthetic Services**

#### **Tissue Conditioning**

**Reline and Rebase** - Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

#### **Repairs, Replacement of Broken Clasp(s)**

**Replacement of Broken Artificial Teeth** - Covered 2 times per 24-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

#### **Denture Adjustments**

## Partial and Bridge Adjustments

**Removable Prosthetic Services (Dentures and Partials)** - Covered once every 5-year period:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

**Fixed Prosthetic Services (Bridge)** - Covered once every 5-year period:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

## Recent Fixed Prosthetic

**Single Tooth Implant Body, Abutment and Crown** - Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that You get a pretreatment estimate to estimate the amount of payment before You begin treatment.

## Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

### Dentally Necessary Orthodontic Care

We will only cover Dentally Necessary Orthodontic Care. To be considered Dentally Necessary at least one of the following must be present:

1. There is spacing between adjacent teeth which interferes with the biting function;
2. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when You bite;
3. Positioning of the jaws or teeth impair chewing or biting function;
4. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
5. Based on a comparable assessment of items 1 through 4, there is an overall orthodontic problem that interferes with the biting function.

You or Your orthodontist should send Your treatment plan to Us for You start treatment to find out if it will be covered under this plan.

Benefits may include the following:

- Limited Treatment Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

- Comprehensive (complete) Treatment Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Pre-orthodontic and Periodic orthodontic treatment visits
- Other Complex Surgical Procedures Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before You were covered by this plan will be covered on a pro-rated basis.

Benefits do not include:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to Your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

**Orthodontic Payments:** Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the plan in order to receive ongoing payments for Your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to Us. An estimate of benefits form will be sent to You and Your orthodontist indicating the estimated Maximum Allowed Amount, including any amount You may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the estimate of benefits form with the date of appliance placement and his/her signature. After We have verified Your plan benefit and Your eligibility, a benefit payment will be issued. A new/revised estimate of benefits form will also be sent to You and Your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

## Dental Appeals

Please submit appeals concerning Your dental coverage to:

Anthem  
PO Box 1122  
Minneapolis, MN 55440-1122

## Vision Care Services for Pediatric Members

We will cover vision care that is listed in this section. See Your "Schedule of Cost Shares and Benefits" for the benefit frequencies and Your cost share amounts for covered vision care. To get the Network benefit, You must use a Blue View Vision provider. If You need help finding a Blue View Vision provider, please visit Our website or call the number on Your ID card. We will not pay for vision care listed in the "Limitations and Exclusions" section.

### Routine Eye Exam

Your policy covers a complete eye exam with dilation as needed. The exam is used to check all aspects of Your vision.

### Eyeglass Lenses



You have a choice in Your eyeglass lenses. Lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received In Network. If You choose lens options that are not listed as covered in the "Schedule of Cost Shares and Benefits," You will have to pay all charges for those options.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

#### **Frames\***

A selection of frames is covered under this plan. Members must choose a frame from the Anthem formulary.

#### **Elective Contact Lenses\***

Elective contact lenses are contacts that You choose instead of eyeglasses for comfort or appearance. You may choose elective contact lenses in lieu of Your eyeglass lenses benefit.

#### **Non-Elective Contact Lenses\***

Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

\*If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed in the "Schedule of Cost Shares and Benefits." A selection of contact lenses is covered under this plan. Members must choose contact lenses from the Anthem formulary.

**SPECIAL NOTE:** We will not reimburse for Non-Elective Contact Lenses for any member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

#### **Vision Appeals**

Please submit appeals regarding Your vision coverage to the following address:

Blue View Vision  
555 Middle Creek Parkway  
Colorado Springs, CO 80921

## 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 Medical Service and is not a covered benefit.

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

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

The amount of payment for the professional service provided via Telemedicine by the Physician or practitioner at the distant site is based on the current Maximum Allowable Amounts for the service provided. The patient (Member) is subject to the applicable Deductible and Coinsurance based upon their benefits.

## Autism Services

Benefits will be provided for the treatment of autism spectrum disorder (ASD) for dependents through age six. Coverage for ASD includes but is not limited to the following:

- Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis shall be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.
- Counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker.
- Therapy services provided by a licensed or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist, or marriage and family therapist.
- Prescription Drugs.

Applied behavior analysis is the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior.

## Ambulance Services

Benefits are provided for ambulance services (air, ground and water) which are Medically Necessary and are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1. From Your home, scene of accident or medical emergency to a Hospital;
  2. Between Hospitals, including when We require You to move from an Out-of-Network Hospital to a Network Hospital; or
  3. Between a Hospital, Skilled Nursing Facility (ground transport only) or approved facility.

You must be taken to the nearest facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a facility that is not the nearest facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a facility.

Non-Network Providers may bill You for any charges that exceed the plan's Maximum Allowed Amount.

### **Ground Ambulance**

Services are subject to medical necessity review by the health plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

### **Air and Water Ambulance**

Air Ambulance Services are subject to medical necessity review by the health plan. The health plan retains the right to select the air ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-emergency Hospital to Hospital transports must be Preauthorized.

### **Hospital to Hospital Air Ambulance Transport**

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such air ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

### **Fixed and Rotary Wing Air Ambulance**

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

## **Clinical Trials**

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following.
  - a. The National Institutes of Health.
  - b. The Centers for Disease Control and Prevention.
  - c. The Agency for Health Care Research and Quality.
  - d. The Centers for Medicare & Medicaid Services.
  - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
  - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific

standards by qualified individuals who have no interest in the outcome of the review.

- i. The Department of Veterans Affairs.
  - ii. The Department of Defense.
  - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
  3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.
  4. Any approved clinical trial program for treatment of children's cancer as defined in O.C.G.A. Section 33-24-59.1.

Your plan may require You to use a Network Provider to maximize Your benefits.

Routine patient care costs include items, services, and drugs provided to You in connection with an approved clinical trial and that would otherwise be covered by this plan.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to Our Clinical Coverage Guidelines, related policies and procedures.

Your plan is not required to provide benefits for the following services. We reserve Our right to exclude any of the following services

1. The investigational item, device, or service, itself; or
2. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

#### **Clinical Trial Programs for the Treatment of Children's Cancer.**

Benefits will be provided for routine patient care cost incurred in connection with the provision of goods, services, and benefits to Dependent children in connection with approved clinical trial programs for the treatment of children's cancer. Routine patient care cost means those pre-certified as Medically Necessary as provided in Georgia law (OCGA 33-24-59.1).

### **Skilled Nursing Care**

Benefits will be provided for skilled nursing care as outlined in the "Schedule of Cost Shares and Benefits." Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Skilled 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 Room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Contract 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; and
- 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 mental illness including drug addiction, chronic brain syndromes and alcoholism, and 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; or
- The care rendered is for other than Skilled Convalescent Care.

## Home Health Care

Benefits will be provided for a home health care program for the Member's care and treatment in the home. 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 Network or Non-Network Providers.

Some special conditions apply:

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

Covered Services:

- Visits by an R.N. or L.P.N. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- 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 environment factors resulting from or affecting the Member's illness.
- Visits by a home health nursing aide when rendered under the direct supervision of an R.N.
- Administration of prescribed drugs.
- Oxygen and its administration.

**NOTE:** Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical, Occupational, Respiratory and Speech Therapy sections as stated in the Schedule of Cost Shares and Benefits.

Home Health Care benefits shall not be provided for:

- Food, housing, homemaker services, sitter and home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care program as described.
- Services of a person who ordinarily resides in the patient's home or is a member of the family or either the patient or patient's spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.

## Hospice Care

Benefits will be provided for hospice care. Hospice care services are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the "Limitations and Exclusions" section for services that are not covered.

- Care rendered by an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) Your Physician and the Hospice medical director must certify that You are terminally ill and generally have less than six months to live, and (2) Your Physician must consent to Your care by the Hospice and must be consulted in the development of Your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to Us upon request.

Additional covered services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

## Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell)

This section describes benefits for certain Covered Transplant Procedures that You get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Contract.

### Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, collection and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

### In-Network Transplant Provider

A Provider that BCBSHP has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to You and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

### **Out-of-Network Transplant Provider**

Any Provider that has NOT been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

### **Unrelated Donor Searches**

When approved by the plan, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

### **Live Donor Health Services**

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

### **Transplant Benefit Period**

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

### **Prior Approval and Precertification**

In order to maximize Your benefits, You will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before You have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call Us to find out which Hospitals are In-Network Transplant Providers. Contact the Customer Service telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an inpatient or outpatient setting.

**Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize Your benefits.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

### **Transportation and Lodging**

The plan will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Transplant evaluation and/or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the

facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by BCBSHP,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver unless a minor,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the mobilization, collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

**Helpful tip:** See the “Schedule of Cost Shares and Benefits” for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

## Other Covered Services

Other medical care includes services rendered personally by Physicians and other health care Providers within their lawful scope of practice. (Certain items and services are excluded. Please read the “Limitations and Exclusions” section of the Contract. Those services which are listed as exclusions will not be paid.)

Such care includes general treatment of illness or injury, any condition requiring an operation, the repair of broken bones or dislocations, and diagnostic studies used to find out the cause of an illness. All care a Member receives must be related to the cause or symptom of the illness or injury. BCBSHP will not pay for treatment which is not Medically Necessary. The Eligible Charge for surgical care includes coverage for the care received both before and after the surgery is performed. Other Covered Services include benefits for the following.

**Medical and surgical care** which is general care and treatment of illness or Injury, and surgical diagnostic procedures including the usual pre- and post-operative care.

**Assistant surgery** services rendered by an assistant surgeon based on Medical Necessity.



**Registered nurse first assistant** services which are provided by 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.

**Outpatient surgical procedures related to the treatment of accidental injury when provided in a Physician's Office** are subject to any applicable Deductible and Coinsurance requirements if applicable, whether by a Network or by a Non-Network Provider.

**Second Medical Opinions** with respect to any proposed surgical intervention, or any medical care that is a Covered Service.

**Reconstructive Surgery** to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

**Note:** This section does not apply to orthognathic surgery.

**Breast Cancer 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.

**Mastectomy Notice** - A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

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

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

**Ovarian cancer surveillance tests** 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 nonpolyposis colorectal cancer; or (b) testing positive for BRCA1 or BRCA2 mutations.

Surveillance test means annual screening using: (a) CA-125 serum tumor marker testing, (b) transvaginal ultrasound, and (c) pelvic examinations.

**Oral surgery** for only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological examination;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Removal of impacted teeth and associated hospitalization, but only if precertified by BCBSHP;
- Treatment of temporomandibular joint syndrome (TMJ) or myofascial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Benefits are not provided for fixed or removable appliances which involve movement or repositioning of the teeth (braces), 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. Such a requirement will not prejudice an existing claim; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to the teeth or structure occurring while a Member is covered by this Contract and performed within 180 days after the accident.

**Operating and treatment rooms and equipment**

**Medical treatment of attention deficit disorder.** Drugs may be prescribed by Your Physician. Only legend Prescription Drugs will be covered.

**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 covered Physician**

**Pacemakers and electrodes**

**Dialysis Treatment.** The Contract will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

**Medically Necessary emergency care in a foreign country.** Please see the "Travel outside the United States – BlueCard Worldwide" section for specific requirements.

**Clinical trial programs for the treatment of children's cancer.** Includes routine patient care cost incurred in connection with the provision of goods, services, and benefits to Dependent children in connection with approved clinical trial programs for the treatment of children's cancer. Routine patient

care cost means those pre-certified as Medically Necessary as provided in Georgia law (OCGA 33-24-59.1).

**Colorectal rectal 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.

**Diabetes** treatment which includes Medically Necessary equipment, supplies, pharmacological agents and outpatient self-management training and education, including nutrition therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by a Physician. The outpatient self-management training and education must be provided by a certified registered or licensed health care professional with expertise in diabetes.

**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 BCBSHP criteria.

**Nutritional counseling** related to medical management of a disease state.

**Cardiac rehabilitation**

**Pulmonary rehabilitation**

**Durable medical equipment** rental charges up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician.

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. BCBSHP may require proof of the ongoing Medical Necessity of any item; and it is related to the patient's physical disorder.

Wheelchairs must also meet the following criteria:

- A physical therapist or clinician must perform a functional evaluation and certify the type of wheelchair to be approved.
- A wheelchair will be considered eligible for replacement after 5 years.

**Prosthetic appliances** to improve or correct conditions resulting from an Accidental Injury or illness are covered if Medically Necessary. Prosthetic devices include cranial prosthetics, artificial limbs and accessories; artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes), and external breast prostheses used after breast removal.

**Hospital visits** by a Physician 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.

**Consultation services** when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury.

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.

**General anesthesia services** 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 administered by a certified registered nurse anesthetist (CRNA) is also covered.

Anesthesia services will not be paid if they are rendered in conjunction with surgical or other care which are Non-Covered Services.

**General anesthesia services for certain dental patients** 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 who are developmentally disabled;
- An individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder; or
- An individual who has sustained extensive facial or dental trauma, except for a Workers' Compensation claim.

Precertification is required.

**Optometrist's 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.

**Physical therapy/occupational therapy, chiropractic care** when services are performed by a Physician, a registered physical therapist (RPT), a licensed occupational therapist (O.T.), a licensed chiropractor (D.C.), or qualified athletic trainers are limited to a combined total maximum visits per calendar year as outlined in the Schedule of Cost Shares and 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.

**Licensed speech therapist services** when Medically Necessary and when ordered and supervised by a Physician limited per calendar year to the total number of visits shown in the Schedule of Cost Shares and Benefits. No coverage is available when such services are necessitated by Developmental Delay.

**Outpatient surgery** in an Hospital outpatient department or Ambulatory Surgery Center as stated in the "Schedule of Cost Shares and Benefits."

**Dental services for Accidental Injury** only when required to diagnose or treat an Accidental Injury to the teeth which occurred on or after Your Effective Date. Services must occur within 180 days of the date of accident.

We also cover the repair of dental appliances damaged as a result of Accidental Injury to the jaw, mouth or face, and dental services to prepare the mouth for radiation therapy to treat head and neck cancer.

Under Your medical and/or surgical benefits, We cover surgical removal of impacted teeth, dental services for Accidental Injury, oral surgery which is not for the supporting structure of the teeth and not intended to benefit the teeth, and diagnostic and surgical services for the treatment of TMJ.

**LIMITATION:** We do not consider Injury as a result of chewing or biting to be an Accidental injury therefore, We do not cover dental services for this type of care.

**Temporomandibular joint syndrome (TMJ)** or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Benefits are not provided for fixed or removable appliances which involve movement or repositioning of the teeth (braces), 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. Such a requirement will not prejudice an existing claim; and

- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to the teeth or structure occurring while a Member is covered by this Contract and performed within 180 days after the accident.

**Anesthesia services for certain dental patients** in an Hospital or ambulatory surgical facility are covered in conjunction with dental care provided to the following:

- Patients age 7 or Younger who are 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.

Precertification is required.

**Newborn services** for the Medically Necessary care and treatment of medically diagnosed congenial defects and birth abnormalities for covered newborns; and

**Inpatient and outpatient dental, oral surgical and orthodontic services** which are Medically Necessary for the Treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia for covered newborns.

**Habilitative/Habilitation Services** are health care services that help You keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Online visits** when available in Your area. Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

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## Limitations and Exclusions

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### Excess Coverage Provision

This coverage pays for eligible charges after any group health plan has paid. In no case shall the total payment of this health care coverage and other coverage exceed 100% of the eligible charges. Eligible charges which are reimbursed by any group health care plan are not covered by this Contract.

### Governmental Programs

Your benefits will be reduced if You are eligible for coverage (even if You did not enroll) under any federal, state (except Medicaid) or local government health care program. Direct questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

### Exclusions

Your Contract does not provide benefits:

- Services rendered by Providers located outside the United States, unless the services are for Emergency Care, urgent care and emergency ambulance.
- For care received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.
- For additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.
- For the following allergy tests and treatment:
  1. IgE RAST tests unless intradermal tests are contraindicated.
  2. Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
  3. Food allergy test panels (including SAGE food allergy panels).
  4. Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.
  5. 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.
- For services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, hypnotherapy, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetics therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide. Self-Help - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
- For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

- For services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
- For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous of Our plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.
- For removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.
- For charges incurred after the termination date of this coverage.
- For charges incurred prior to Your Effective Date.
- For cochlear implants.
- For complications directly related to a service or treatment that is a non-Covered Service under this Contract because it was determined by Us to be Experimental or Investigative or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental or Investigative or non-Medically Necessary service and would not have taken place in the absence of the Experimental or Investigative or non-Medically Necessary service.
- For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
- For 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 BCBSHP, is not covered.
  1. 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
  2. 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.

3. This exclusion does not apply to breast reduction surgery. Please see the "Benefits" section of this Contract.
- For counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy
  - For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.
  - For injuries received while committing a crime as long as any injuries are not a result of a medical condition or an act of domestic violence.
  - For services, supplies, etc. for the following:
    1. Custodial Care, convalescent care or rest cures.
    2. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    3. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    4. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
    5. Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

- For dental braces or (unless) specifically stated as a Covered Service.
- For dental implants or (unless) specifically stated as a Covered Service.
- For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. Dental treatment includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
  1. Extraction, restoration and replacement of teeth.
  2. Medical or surgical treatments of dental conditions.
  3. Services to improve dental clinical outcomes.
- For dental X-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service. The only exceptions to this are for any of the following:
  1. Transplant preparation.
  2. Initiation of immunosuppressives.
  3. Direct treatment of acute traumatic injury, cancer, or cleft palate.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For abortions for which Federal funding is not allowed in accordance with Affordable Care Act section 1303(b)(1)(B)(i), namely all abortions except in the case of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed.



- For examinations relating to research screenings.
- For Experimental or Investigative services or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental or Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental or Investigative.
- For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
- For prescribed, ordered or referred by, or received from a member of Your immediate family, including Your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.
- For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
  1. For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:  
Cleaning and soaking the feet.
  2. Applying skin creams in order to maintain skin tone.
  3. Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For surgical treatment of gynecomastia.
- For hearing services, hearing aids, hearing devices and related or routine examinations and services.
- For human growth hormone.
- For treatment of hyperhidrosis (excessive sweating).
- For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- For artificial insemination, in vitro fertilization, other types of artificial or surgical means of conception including drugs administered in connection with these procedures.
- For Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Member is medically stable and does not require Skilled Nursing Convalescent Care or the constant availability of a Physician or:
  1. The treatment is for maintenance therapy; or
  2. The Member has no restorative potential; or
  3. The treatment is for congenital learning or neurological disability/disorder; or
  4. The treatment is for communication training, educational training or vocational training.
- For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of

functioning and prevents loss of that functioning, but which does not result in any additional improvement.

- For manipulation therapy services rendered in the home unless specifically stated as covered under the Home Health Care Services benefit.
- In excess of Our Maximum Allowable Amounts.
- Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.
- (1) for which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.
- For missed or canceled appointments.
- For any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Which You have no legal obligation to pay in the absence of this or like coverage.
- For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.
- For care received in an emergency room that is not emergency care, except as specified in this Contract. This includes, but is not limited to, suture removal in an emergency room.
- For non-emergency treatment of chronic illnesses received outside the United States performed without pre-certification.
- For nutritional and dietary supplements, except as provided in the “Benefits” section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.
- For benefits for care available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
  1. The part of any charge that is more than the other coverage’s benefit or
  2. The benefit We would pay if You had no other coverage.
- Other medical or dental expense coverage includes, but is not limited to:
  1. Individual or family plan health insurance;
  2. Group health insurance
  3. Automobile insurance
- For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law;

- For personal hygiene, environmental control, or convenience items including but not limited to:
  1. Air conditioners, humidifiers, air purifiers;
  2. Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
  3. Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
  4. Charges from a health spa or similar facility;
  5. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
  6. Charges for non-medical self-care except as otherwise stated;
  7. Purchase or rental of supplies for common household use, such as water purifiers;
  8. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
  9. Infant helmets to treat positional plagiocephaly;
  10. Safety helmets for Members with neuromuscular diseases; or
  11. Sports helmets.
- For 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 Contract. We do not cover vaccinations, immunizations or other injections not used to treat a current illness except as provided under the Child Wellness Services or Preventive Services.
- For stand-by charges of a Physician.
- For private duty nursing services unless specifically stated in the "Benefits" section,
- For private rooms, except as specified as specified as Covered Services.
- For provider services You get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such Providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.
- For reconstructive services except as specifically stated in the "Benefits" section, or as required by law.
- For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.
- For reversal of sterilization.
- For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.
- For sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

- For biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
- For services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
- For extracorporeal shock wave treatment for plantar fasciitis and other musculoskeletal conditions.
- For treatment of telangiectatic dermal veins (spider veins) by any method.
- For spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.
- For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- For treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.
- For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- For services, supplies, and equipment for the following:
  1. Gastric electrical stimulation.
  2. Hippotherapy.
  3. Intestinal rehabilitation therapy.
  4. Prolotherapy.
  5. Recreational therapy.
  6. Sensory integration therapy (SIT).
- For transportation provided by other than a state licensed professional ambulance service, and ambulance service other than in a Medical Emergency.
- For vision orthoptic training.
- For any service for which You are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible (if any) and the Copayment, Coinsurance or Deductible (if any) is waived by a Non-Network Provider.
- For any services or supplies for the treatment of obesity, including but not limited to, weight reduction, surgical care, medical care or Prescription Drugs, or dietary control related to covered nutritional counseling. Nutritional and/or dietary supplements except as provided in this Contract or as required by law. This exclusion includes, but is not limited to those for nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by licensed pharmacists; 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, surgical or psychiatric care or counseling. Weight loss programs, nutritional supplements, or psychiatric care or counseling. Weight loss programs, whether or not

they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs; nutritional supplements, appetite suppressants, and supplies of a similar nature. Procedures including but not limited to liposuction, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, and wiring of the jaw.

- For hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
- For non-interactive telemedicine services
- For 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 BCBSHP feels do not meet the listed criteria. shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace). 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 Member's house or place of business, and adjustments made to vehicles.
- For 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 extent that the Contract covers autism in the "Benefits" section), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered. 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.
- For ambulance usage when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician

is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to, trips to:

1. A Physician's office or clinic;
  2. A morgue or funeral home.
- Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or Physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, Physician's office, or Your home.
  - For items related to prescription drug services:
    1. Administration Charges - charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manger (PBM).
    2. Clinically-Equivalent Alternatives - Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by BCBSHP to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to BCBSHP, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.
    3. Compound Drugs.
    4. Contrary to Approved Medical and Professional Standards Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
    5. Delivery Charges: Charges for delivery of Prescription Drugs.
    6. Drugs Given at the Provider's Office/Facility Drugs You take at the time and place where You are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
    7. Drugs that do not need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a Physician.
    8. Drugs Over Quantity or Age Limits Drugs in quantities which are over the limits set by BCBSHP, or which are over any age limits set by Us.
    9. Drugs Over the Quantity Prescribed or Refills After One Year Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
    10. Items Covered as Durable Medical Equipment (DME) Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
    11. Over the counter Drugs, devices or products, are not Covered Services.
    12. An allergenic extract or vaccine.
    13. Lost or Stolen Drugs Refills of lost or stolen Drugs.
    14. Mail service programs other than the PBM's home delivery mail service - Prescription Drugs dispensed by any mail service program other than the PBM's home delivery mail Service, unless We must cover them by law.

15. Non-approved Drugs: Drugs not approved by the FDA.
  16. Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
  17. Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
  18. Over-the-Counter Items Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
  19. Sex Change Drugs: Drugs for sex change surgery.
  20. Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
  21. Syringes - Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
  22. Weight Loss Drugs - Any Drug mainly used for weight loss.
  23. Drugs used for cosmetic purposes.
  24. Prescription Drugs used to treat infertility.
- For Hospice Care. The following services, supplies or care are not covered:
    1. Services or supplies for personal comfort or convenience, including homemaker services.
    2. Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
    3. Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
    4. Services provided by volunteers.
  - Your Vision care services do not include services:
    1. Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract
    2. For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.
    3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
    4. For which the member has no legal obligation to pay in the absence of this or like coverage.
    5. Prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
    6. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
    7. For missed or canceled appointments.
    8. For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this booklet or as otherwise prohibited by federal law.
    9. For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.

10. Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network Provider).
  11. For safety glasses and accompanying frames.
  12. For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Contract.
  13. For orthoptics or vision training and any associated supplemental testing.
  14. For two pairs of glasses in lieu of bifocals.
  15. For plano lenses (lenses that have no refractive power).
  16. For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Contract.
  17. For lost or broken lenses or frames, unless the member has reached the Member's normal interval for service when seeking replacements.
  18. For services or supplies not specifically listed in this Contract.
  19. For cosmetic lenses or options.
  20. For blended lenses.
  21. For oversize lenses.
  22. For certain limitations on low vision.
  23. For optional cosmetic processes.
  24. For sunglasses.
  25. For services or supplies combined with any other offer, coupon or in-store advertisement.
  26. For certain frame brands in which the manufacturer imposes a no discount policy.
- Your dental care services do not include services incurred for, or in connection with any of the items below:
    1. Dental care for Members age 19 and older.
    2. Dental services which a Member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Member receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a Subscriber or Dependent who is eligible for or receiving medical assistance.
    3. Dental services or health care services not specifically covered under the Contract (including any hospital charges, Prescription Drug charges and dental services or supplies that are medical in nature).
    4. New, Experimental or Investigational dental techniques or services may be denied until there is, to Our satisfaction, an established scientific basis for recommendation.
    5. Dental services completed prior to the date the Member became eligible for coverage.
    6. Services of anesthesiologists.
    7. Anesthesia services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.



8. Intravenous conscious sedation, IV sedation, general anesthesia, medicines, or Drugs for non-surgical or surgical dental care.
9. Dental services performed other than by a licensed dentist, licensed Physician, his or her employees.
10. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
11. Services or supplies that have the primary purpose of improving the appearance of Your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
12. Case presentations.
13. Incomplete, interim or temporary services, including fixed prosthetic appliances (dentures, partials or bridges).
14. Enamel microabrasion and odontoplasty.
15. Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
16. Bacteriologic tests. Please refer to Your medical coverage to determine if this is a covered medical benefit.
17. Cytology sample collection. Please refer to Your medical coverage to determine if this is a covered medical benefit.
18. Separate services billed when they are an inherent component of another covered service.
19. Services for the replacement of an existing partial denture with a bridge.
20. Additional, elective or enhanced prosthodontic procedures including connector bar(s), stress breakers and precision attachments.
21. Provisional splinting, temporary procedures or interim stabilization.
22. Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
23. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital. Please refer to Your medical coverage to determine if this is a covered medical benefit.
24. Pulp vitality tests.
25. Adjunctive diagnostic tests.
26. Incomplete root canals.
27. Cone beam images.
28. Anatomical crown exposure.
29. Temporary anchorage devices.
30. Sinus augmentation.
31. Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive or cosmetic purposes.
32. Temporomandibular Joint Disorder (TMJ) except as covered under Your medical coverage.
33. Oral hygiene instructions.

34. Repair or replacement of lost/broken appliances is not a covered benefit.
35. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
36. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
37. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

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## Claims and Payments

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### Hospital Services

BCBSHP's payment to the Network or Participating Hospital where You receive care will be for the total amount of coverage You have under this Contract. All care must be consistent with the terms of this Contract. You may choose the Hospital at which care will be rendered; however, Your out-of-pocket expenses are higher when You receive care from Non-Network Providers.

Payment of benefits for Eligible Charges will be made directly to You, the Subscriber, for treatment received in a Non-Network or Non-Participating Hospital if You do not assign benefits to such Hospital.

All determinations of payment are based on the applicable Reimbursement Rate or negotiated fees. Benefits are assignable.

### Physician Services

We may pay either Your Physician or You for any care which You have received. Payment will be for the amount due under this Contract. Benefits are assignable.

No salaried employee of a Hospital will receive direct payment for Physician services. This also includes resident Physicians and interns.

All determinations of payment are based on UCR Fees, Reimbursement Rate, negotiated fees, or a pre-determined fee schedule.

### Other Services or Supplies

BCBSHP may pay amount due under this Contract for other services or supplies to You or any Provider entitled to such a payment. This payment is at the option of BCBSHP.

## What Your Coverage Covers

### Percentage Payable

After any applicable Deductible is met, the percentage payable by BCBSHP is stated in the "Schedule of Cost Shares and Benefits." The portion which You must pay (the out-of-pocket amount) is stated in the "Schedule of Cost Shares and Benefits." Once Your separate Out-of-Pocket Limit for Network services is reached eligible benefits for those Network services are paid at 100% of the Maximum Allowable Amount during the remainder of the calendar year.

Eligible charges are determined by: (a) BCBSGA's usual, customary, and reasonable (UCR) fees; (b) a Provider's contracted fee schedule; (c) the applicable Maximum Allowed Amount; or (d) negotiated fees. Reimbursement for Preferred, Participating and Out-of-Network Providers is based on eligible charges for the type of service a Member receives (for example, Hospital or Physician services). Reimbursement for Non-Contracted Providers is determined by Our default reimbursement rate which is the rate paid to any Provider that does not participate in any of BCBSGA's Networks (or any of its affiliates). The default reimbursement rate will never be greater than the Maximum Allowed Amount for any contracted Provider.

The percentage of the bill payable is determined after Non-Covered Services have been deducted. For example, this Contract covers the charge for a Semi-private Room. If You stay in a private room, You must pay the difference between these two charges.

In order to receive benefits, You must be admitted to a Hospital or receive treatment on or after Your individual Effective Date and meet any applicable Deductible.

### **Deductible Calculation**

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how Your plan works, please refer to the "Schedule of Cost Shares and Benefits."

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

### **Out-of-Pocket Limit Calculation**

The Deductible, Coinsurance,\* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that calendar year. No one person can contribute more than their individual Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Network Cost Sharing will be required for the remainder of the calendar year, except for Out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

\*The Out-of-Network Out-of-Pocket Limit does not include Coinsurance for any Out-of-Network Human Organ Tissue Transplant.

## **Maximum Allowed Amount**

### **GENERAL**

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

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

- That meet Our definition of Covered Services, to the extent such services and supplies are covered under Your benefit program and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in Your benefit program.

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 a Non-Participating Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

Generally, services received from an Out-of-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by us. When you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference

between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a 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 only 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.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount 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 a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific benefit program or in a special center of excellence/or other closely managed specialty Network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this plan is the rate the Provider has agreed with BCBSHP to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, 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 a Participating Provider or visit Our website at [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 Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers.

For Covered Services You receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this plan will be one of the following as determined by BCBSHP:

1. An amount based on Our Non-Participating Provider 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 for like/similar Providers, contracted with BCBSHP, 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 reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, BCBSHP will update such information, which is unadjusted for geographic locality, no less than annually; 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.
5. An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with BCBSHP are also considered Non-Participating. For this plan the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between BCBSHP and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating 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 a Participating Provider will likely result in lower out-of-pocket costs to You. Please call Customer Service for help in finding a Participating Provider or visit BCBSHP's website at [www.bcbsga.com](http://www.bcbsga.com).

Customer Service is also available to assist You in determining this plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for BCBSHP 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.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by BCBSHP using Prescription Drug cost information provided by the Pharmacy Benefits Manager (PBM).

## MEMBER COST SHARE

For certain Covered Services and depending on Your Benefit Program, 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 Limit may vary depending on whether You received services from a Participating or Non-Participating Provider. Please see the "Schedule of Cost Shares and Benefits" in this Contract for Your Cost Share responsibilities and limitations, or call Customer Service to learn how this Benefit Program or Cost-Share amounts may vary by the type of Provider You use.

BCBSHP 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 a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your policy/plan/ benefit program, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Your day/visit limits

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

## Authorized Services

In some non-emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, You must contact BCBSHP in advance of obtaining the Covered Service. We also will authorize the Participating Cost Share amounts to apply to a claim for Covered Services if You receive emergency services from a Non-Participating Provider and are not able to contact BCBSHP until after the covered service is rendered. If We authorize a Network cost share amount to apply to a Covered Service received from a Non-Participating Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

**Example:**

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in Your local Network area. You contact BCBSHP in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a \$25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because We have authorized the Participating Cost Share amount to apply in this situation, You will be responsible for the Participating Copayment of \$25 and BCBSHP will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is \$500, You may receive a bill from the Non-Participating Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with Your Participating Copayment of \$25, Your total out-of-pocket expense would be \$325.

**BALANCE BILLING**

Network and Participating Physicians are prohibited from Balance Billing. A Network or Participating Physician has signed an agreement with BCBSHP to accept Our determination of the usual, customary and reasonable fee or Reimbursement Rate for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Contract, e.g., Deductibles (if any) or Coinsurance.

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## Appeals and Complaints

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### Contract Administration

For proper adjudication of claims under this Contract, it is agreed, and the Member consents, that all medical records involving any condition for which a claim is presented will be furnished at BCBSHP's request and all privileges with respect to such information, are waived. The Member agrees to participate and cooperate with BCBSHP in any pre-admission, concurrent or other medical review activity at any Hospital or Medical Facility as BCBSHP deems appropriate. This information will be kept confidential to the extent provided by law. Payment will not be provided where sufficient information cannot be obtained to properly adjudicate a claim.

Any person or entity having information about an illness or Injury for which benefits are claimed may give BCBSHP, at its request, any information (including copies or records) about the illness or Injury. In addition, BCBSHP may, with the Member's written consent, give any person or entity similar information at their request if they are providing similar benefits.

In making a decision on claims involving payment for services or supplies or days of care that are determined by BCBSHP to be Medically Necessary, BCBSHP reserves the right to obtain advisory opinions from Physician consultants in the appropriate specialty under consideration prior to reaching a decision. On reconsideration of denied Medical Necessity claims, BCBSHP further reserves the right to refer such cases to an appropriate peer review committee for an advisory opinion before BCBSHP renders its final determination on such claims.

Please refer to the Section "Prescription Drug List" for the process for submitting an exception request for Drugs not on the Prescription Drug List.

BCBSHP will not cover the costs and/or copying of medical records.

### Notice of Claims, Proof of Loss and Claim Forms

Most claims will be filed for You by Network Providers. You may have to file a claim if You receive Non-Network care in an emergency situation. Under normal conditions a Member should file a claim within 90 days after the service was provided. Failure to file such claim within the required time will not invalidate or reduce the claim if it was not reasonably possible to file such claim.

You have 24 months after the date of service to file Your proof of loss. We do not provide benefits for a claim if proof of loss is not received within 24 months. The only exception to this 24 month limitation is if You are not legally competent to act.

All notices of claims, proofs of loss, and claim forms should be sent to the following address:

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.  
P.O. Box 9907  
Columbus, Georgia 31908-9907

You must include Your identification number so that BCBSHP can verify that You are an active Member.

You can get claim forms at Network and Participating Hospitals and Physician's offices. You may also get claim forms directly from BCBSHP so You can file a claim personally. These forms must be given to You within 10 days after You ask for them. If You do not receive these forms within these 10 days, any written proof of loss submitted by You (such as a letter or a photocopy of all bills involved) will be considered for payment.

### Time of Payment of Claims

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, BCBSHP will notify You within 15



working days, for electronic claims and 30 calendar days, for paper claims of the reason for the delay and list all information needed to continue processing Your claim. After this data is received by BCBSHP, claims processing will be completed during the next 15 working days for electronic claims and 30 calendar days for paper claims. BCBSHP shall pay interest at the rate of 12% per year to You or the assigned provider if it does not meet these requirements.

## Questions About Coverage or Claims

If You have questions about Your coverage, contact the BCBSHP Customer Service Department. Be sure to always give Your BCBSHP Member number.

If You wish to get a full copy of the Utilization Review program procedures, contact the Customer Service Department.

## Explanation of Benefits

For all claims submitted by You or in Your behalf, You will receive a notice (Explanation of Benefits) showing the amount of the charges, the amount paid by the program, and, if payment is partially or wholly denied, the reason. If Your claim is denied, You can appeal in accordance with documentation provided on the EOB or call Customer Service at the number on Your Identification Card.

When asking about a claim, give the following information:

- Your BCBSHP Member Number,
- Patient name and address,
- Date of service, type of service received, and
- Provider name and address (Hospital or Physician).

## We Want You To Be Satisfied

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

## Complaints about BCBSHP Service

As a BCBSHP Member, You have a right to express dissatisfaction and to expect unbiased resolution of issues. Complaints typically involve issues such as dissatisfaction about BCBSHP services, quality of care, the choice of and accessibility to Providers and network adequacy.

The following represents the process We have established to ensure that We give Our fullest attention to Your concerns. Please call the Customer Service Department at the number on Your ID card. Tell Us Your concern and We will work to resolve it for You as quickly as possible.

Appealing an Adverse Benefit Determination - If We have rendered an adverse benefit determination, such as determining that a requested service is not Medically Necessary or is considered Investigational or Experimental, please do the following:

- a. Call the Customer Service Department within 120 days of receiving the adverse determination and let the representative know that You would like to appeal the decision. The Customer Service representative will discuss any appeal options that may be available. The phone number is on Your ID card.
- b. If You have appeal rights available, You were sent a description of those appeal rights with Our determination.
- c. At the conclusion of this formalized re-review (Your initial appeal) a written response will be sent to You explaining Our determination.
- d. If You remain dissatisfied You may be provided an opportunity for another appeal. This is explained in the appeal attachment sent with Our determination, or You can again call Customer Service for assistance. Depending upon the nature of Your appeal, You may be offered the option of participating in a voluntary second level of internal appeal. Again the decision is sent to You in writing, and will also include information on additional appeal rights, when available.

- e. The final level of review is performed by a reviewers associated with an independent review organization. You may wish to skip the voluntary second level of review described above and go from the Initial appeal to a request for an independent review. Whether You participate in or decline the voluntary second level of review, a final level of appeal to an independent review organization is generally available (again depending upon the nature of Your claim). The decision rendered by the independent reviewer associated with the independent review organization is binding on You and Us.
- f. Customer Service is available to You to guide You through this process.

## **Summary of Grievances**

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

## **Right to Receive Necessary Information**

BCBSHP has the right to receive any information necessary in order to determine how much to cover on any claims submitted by a Hospital, Physician or an individual Member. BCBSHP agrees to hold all such material confidential.

## **Unauthorized Use of Identification Card; Fraudulent Statements**

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

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

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## Eligibility and Enrollment

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### Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1. Be a United States citizen or national; or
2. Be a legal resident of Georgia;
3. Submit proof satisfactory to BCBSHP to confirm dependent eligibility;
4. Agree to pay for the cost of Premium that BCBSHP requires;
5. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
6. Not be incarcerated (except pending disposition of charges);
7. Not be entitled to or enrolled in Medicare Parts A/B and or D;
8. Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which You:

1. Reside, intend to reside (including without a fixed address); or
2. The area in which You are seeking employment (whether or not currently employed); or
3. Have entered without a job commitment.

### Dependents

To be eligible for coverage to enroll as a Dependent, You must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1. The Subscriber's legal spouse.
2. The Subscriber's Domestic Partner - Domestic Partner or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
  - For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.
  - A Domestic Partner's or a Domestic Partner's child's coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
  - To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3. The Subscriber's, the Subscriber's Domestic Partner's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.
4. Children under age 26 for whom the Subscriber, the Subscriber Domestic Partner or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The plan must certify the Dependent's eligibility. The plan must be informed of the Dependent's eligibility for continuation of

coverage within 31 days after the date the Dependent would normally become ineligible. You must notify Us if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

## Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

## Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- Loss of Minimum Essential Coverage due to dissolution of marriage;
- Marriage;
- Adoption or placement for adoption; and
- Birth

### Newborn and Adopted Child Coverage

We automatically cover the Subscriber's newborn and/or an adopted child for 31 days from the date of birth, from placement or final decree, which occurs first. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the plan and pay any applicable Premium during this 31 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to You. The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption.

### Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

### Qualified Medical Child Support Order

If You are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll Your child under this Contract, and the child is otherwise eligible for the coverage, We will permit Your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

## Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following calendar year. The actual Effective Date is determined by the date BCBSHP receives a complete application with the applicable Premium payment.

**Effective Dates** for Special Enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2. In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after Your application is received.

**Effective Dates** for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee of Subscriber;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
  - Individual who no longer resides, lives or works in the Plan's Service Area,
  - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
  - Termination of employer contributions, and
  - Exhaustion of COBRA benefits.

**There is no special enrollment for loss of Minimum Essential Coverage when the loss includes termination** or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

## Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the **Premium due date, provided the following requirements are satisfied:**

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this coverage, subject to the incontestability provision; and
3. Membership has not been terminated by BCBSHP under the terms of this Contract.

## Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no

longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

## **Statements and Forms**

Subscribers or applicants for membership shall complete and submit to the plan applications or other forms or statements the plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

## **Delivery of Documents**

We will provide a Contract for each Subscriber.

## When Your Coverage Terminates

This section describes how coverage for a Member can be terminated, cancelled, rescinded, suspended or not renewed.

### Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to BCBSHP.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage

### Effective Dates of Termination

Except as otherwise provided, Your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on Your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If You terminate Your coverage, termination will be effective on the last day of the billing period in which We received Your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If You permit the use of Yours or any other Member's plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, Your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If You engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if You knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with the Contract, then We may terminate Your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage is terminated.
- If You stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

**IMPORTANT:** Termination of the Contract automatically terminates all Your coverage as of the date of termination, whether or not a specific condition was incurred prior to the Termination date. Covered Services are eligible for payment only if Your Contract is in effect at the time such services are provided.

### Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be terminated, canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this coverage; and
3. Membership has not been terminated by BCBSHP under the terms of this Contract.

## Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding Your eligibility and the eligibility of Your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

## Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependents did not disclose on Your application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependent did not disclose on the application, We may terminate or rescind coverage for the additional Dependent as of his or her original Effective Date. We will give You at least 30 days written notice prior to rescission of this Contract. You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services.

After the two (2) years following Your Effective Date, We may only rescind or terminate Your coverage on the basis of any act, practice or omission that constitutes fraud.

## Discontinuation of Health Coverage

We can refuse to renew Your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide You with at least 90 days notice of the discontinuation. In addition, You will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

## After Termination

Once this Contract is terminated, the former Member cannot reapply until the next annual open enrollment unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

## Grace Period

This Contract has a 31-day Grace Period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force unless prior to the date Premium payment is due You give timely written notice to BCBSHP that the Contract is to be terminated. If You do not make the full Premium payment during the grace period, the Contract will be terminated on the last day of the grace period. You will be liable to BCBSHP for the Premium payments due including those for the grace period. You will also be liable to BCBSHP for any claims payments made for services incurred after the grace period.

## Removal of Members

A Subscriber may terminate the enrollment of any Member from the plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

## Refund of Premium

Upon termination, We shall return promptly the unearned portion of any Premium paid.



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## General Provisions

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### Entire Contract and Changes

Your Application for Coverage, this document, any later applications, and any future attachments, additions, deletions, or other amendments will be the entire Contract. No change in this Contract is valid unless signed by the President of BCBSHP. No agent or employee of BCBSHP may change this Contract or declare any part of it invalid.

BCBSHP has the right to amend this Contract at any time by giving You written notice of the amendment at least 90 days before the amendment takes effect. You must agree to the change in writing. However, this requirement of notice shall not apply to amendments which provide coverage mandated by the laws of the State of Georgia.

### Change Notification - Members

Members may notify BCBSHP of any changes which would affect coverage at BCBSHP's office:

Blue Cross Blue Shield Healthcare Plan of Georgia  
P.O. Box 9907  
Columbus, GA 31908

### Change Notification - Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.

BCBSHP may notify Members of any changes at the Member's address as it appears in BCBSHP's records. Please notify BCBSHP when You change Your address by calling Our Customer Service Department. If You move and are a resident of another state, You may be eligible for either another Blue Cross Blue Shield Plan, a plan offered by another carrier or a government-sponsored program. A BCBSHP Customer Service representative will have forms available that can help guide You to other Blue Cross Blue Shield plans that may be available to You.

### Time Limit on Certain Defenses

BCBSHP may cancel this coverage within two (2) years from the Effective Date for any ineligible family member on whom fraudulent information has been submitted. The Member assumes liability for reimbursement to BCBSHP for any benefit payment made on behalf of such family Member.

Two years after this Contract is issued, no false statements which might have been in Your Application for Coverage can be used to void the Contract. Also, after these same two years no covered claim can be denied because of any false statement on Your Application unless found to be made intentionally.

One year after this Contract is issued, no claim can be reduced or denied simply because You had a disease or condition prior to Your Effective Date. This section does not remove the limits on services which are excluded from payment.

### Reinstatement

If Your coverage ends in any manner, You may be considered for reinstatement.

However, if Your coverage ended because You did not make payments, coverage under a reinstatement is limited to covering Accidental Injuries from the date of reinstatement and any illness which begins 10 days after Your reinstatement. Your rights in all other areas of this Contract remain the same as before the due date of the charges which You did not pay.

BCBSHP does not require an application for reinstatement. However, if in the future BCBSHP requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Contract

will be reinstated upon approval, upon the 45th day following the date of such conditional receipt unless BCBSHP has previously notified the insured in writing of its disapproval of such application.

## Physical Examinations

If You have submitted a claim and BCBSHP needs more information about Your health, BCBSHP can require You to have a physical examination. BCBSHP would cover the cost of any such examination.

## Legal Action

No lawsuit may be filed by a Member to recover benefits on a claim made until 60 days after the submission of a claim. A Member cannot file any legal action after three (3) years from the date of service.

## Assignment of Benefits

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

## Unreasonable Fees

If BCBSHP considers a charge unreasonable, it will determine a customary fee. Payment will be based on the customary fee.

## Compliance with Given Provisions

BCBSHP has the right to waive any part of this Contract. This waiver in no way affects BCBSHP's right to apply that part of the Contract in paying a future claim.

## Change in Premium Charge

Your Premium charge may change based on Your place of residence, age, and type of coverage. The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 60 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Additionally, BCBSHP reserves the right to change the Premium charge due for this coverage by giving sixty (60) days written notice.

The Premium amount due for this Contract may change because of adding a Dependent or terminating coverage of a Dependent. Please tell Us in writing as soon as any of the following happens:

- The Subscriber and the covered spouse divorce;
- The end of the month a covered Dependent child reaches age 26;
- A covered person begins active duty with the Armed Services;
- Death of the Dependent; or
- A child is born to or adopted by the Subscriber.

Please see the "Eligibility" section for information on converting or ending coverage under this Contract.

## Unpaid Premium

Upon the payment of a claim under this Contract, any Premiums then due and unpaid or covered by any note or written order may be deducted from that claim payment.

## Applicable Law

This Contract will be governed by the laws and regulations of the State of Georgia. Nothing in this Contract shall be construed so as to be in violation of any federal or state law or regulation. Any changes to the provisions or which affect the rates under this Contract required by changes in any such law or regulations shall become effective upon sixty (60) days written notice.

## Care Received Outside the United States

You will receive Contract benefits for care and treatment received outside the United States. However, non-emergency treatment of chronic illnesses received outside the United States must be pre-certified. Please pay the Provider of service at the time You receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with Your claim. All services will be subject to appropriateness of care. We will reimburse You directly for Covered Services. Assignments of benefits to foreign providers or facilities cannot be honored. However, if You do not maintain residence in the United States, the coverage will be cancelled.

## Licensed Controlled Affiliate

The Subscriber hereby expressly acknowledges understanding this policy constitutes a contract solely between the Subscriber and BCBSHP, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSHP to use the Blue Cross and/or Blue Shield Service Marks in the state of Georgia, and that BCBSHP is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that he/she has not entered into this policy based upon representations by any person other than BCBSHP and that no person, entity, or organization other than BCBSHP shall be held accountable or liable to Subscriber for any of BCBSHP's obligations to the Subscriber created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSHP other than those obligations created under other provisions of this agreement.

## Voluntary Clinical Quality Programs

We may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that You have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under Your plan. These programs are not guaranteed and could be discontinued at any time. We will give You the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards or retailer coupons, which We encourage You to use for health and wellness related activities or items. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If You have any questions about whether receipt of a gift card or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.)

## Medical Policy and Technology Assessment

BSBSHP reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental or Investigational status or Medical Necessity of new technology. Guidance and external validation of BBSBSHP's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including BCBSHP's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

## Fees

An administrative fee of 20 will be charged for any check, automatic deduction, or electronic funds transfer which is returned or dishonored by the financial institution as non-payable to BCBSHP for any reason.

## Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on Pharmacy products (over-the-counter Drugs, consultations and biometrics).

In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the plan but are in addition to plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

## Terms of Your Coverage

1. BCBSHP provides the benefits described in this Contract only for eligible Members. The health care services are subject to the limitations, exclusions, Deductible (if any) and Coinsurance requirements specified in this Contract.
2. Benefit payment for Covered Services or supplies will be made directly to Network or Participating Physicians. A Member may assign benefits to a provider who is not a Network or Participating Provider, but it is not required. If a Member does not assign benefits to a Non-Network or Non-Participating Provider, any benefit payment will be sent to the Member.
3. BCBSHP is not responsible for any injuries or damages You may suffer due to actions of any Hospital, Physician or other person.
4. In order to process Your claims, BCBSHP may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.
5. An oral explanation of Your benefits by a BCBSHP employee is not legally binding.
6. Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying BCBSHP of Your new address.

## Acts Beyond Reasonable Control (Force Majeure)

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

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## Definitions

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### **Accidental Injury**

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

### **Admission**

Begins the first day You become a registered Hospital bed patient and continues until You are discharged.

### **Applicant**

You. The person who applied for this Contract.

### **Application for Coverage**

The original and any subsequent forms completed and signed by the Subscriber seeking coverage.

### **Benefit Payment**

The amount We will pay for Covered Services.

### **Benefit Period**

One year, January 1 to December 31 (also called "year" or "calendar year"). Benefit Period can also mean a part of a calendar year if Your Effective Date is other than January 1, or if You cancel Your coverage before December 31. During Your first policy year, the Benefit Period extends from Your Effective Date through December 31 of that calendar year. It does not begin before Your Effective Date. It does not continue after Your coverage ends. However, BCBSHP will not prejudice an existing claim.

### **Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.**

The company legally responsible for providing the Benefit Payments under this Contract. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. is referred to as "We," "Us," "Our," and "BCBSHP."

### **Brand Name Drug**

Prescription Drugs that the Pharmacy Benefits Manager (PBM) has classified as Brand Name Drugs through use of an independent proprietary industry database.

### **Chemical Dependency Treatment Facility**

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

### **Coinsurance**

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the Maximum Allowed Amount for the service. You pay Coinsurance plus any Deductibles You owe. For example, if the health insurance or Plan's Maximum Allowed Amount for an office visit is \$100 and You've met Your Deductible, Your Coinsurance payment of 20% would be \$20. The health insurance or Plan pays the rest of the Maximum Allowed Amount. It is the percent that You must pay for a Covered Service per calendar year in addition to the Deductible and Copayment (if any).

### **Congenital Anomaly**

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

**Contract**

Your application and this document. It also includes any later applications for membership, and any attachments, additions, deletions, or other amendments to the Contract and the BCBSHP Formulary.

**Copayment**

A fixed amount (for example, \$15) You pay for a covered health care service, usually when You receive the service. The amount can vary by the type of covered health care service.

**Cosmetic Surgery**

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

**Cost-Sharing**

The amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

**Covered Dependent**

Any Dependent in a Subscriber's family or Domestic Partner who meets all the requirements of the "Eligibility" section of this Contract, has enrolled in the Contract, and is subject to Premium requirements set forth in the Contract.

**Covered Services**

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

**Custodial Care**

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; or (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement.

Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel.

Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of BCBSHP, can be safe and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

**Deductible**

The amount of charges You must pay for any Covered Services and Prescription Drugs before any benefits are available to You under this Agreement. Your Deductible is stated in Your "Schedule of Cost Shares and Benefits." The Deductible may be separate from the annual Deductibles for medical benefits

and may or may not accumulate towards satisfying the medical Participating or Non- Participating Provider Deductibles.

### **Dentally Necessary Orthodontic Care**

A service for pediatric members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the Dentally Necessary Orthodontic Care benefit description in the “Benefits” section for more information.

### **Developmental Delay**

The statistical variation in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury. Services rendered should be to treat or promote recovery of the specific functional deficits identified.

### **Durable Medical Equipment**

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

### **Effective Date**

The date BCBSHP approves an individual Application for Coverage. Coverage will take effective as of 12:01 a.m. on Your Effective Date. Effective date is discussed in more detail in the “Eligibility” article of this Contract.

### **Experimental or Investigational**

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

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

**Family Coverage**

Coverage for You, Your spouse, and any eligible children.

**Formulary**

A listing of Prescription Drugs that are determined by BCBSHP in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by BCBSHP in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other BCBSHP products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by BCBSHP. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at [www.bcbsga.com](http://www.bcbsga.com).

**Freestanding Ambulatory Facility**

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (RNs). A Physician's office does not qualify as a freestanding ambulatory facility.

**Generic Drugs**

The term **Generic Drugs** means that the PBM has classified these Drugs as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

**Home Health Care**

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

**Home Health Care Agency**

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

**Hospice**

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

**Hospice Care**

A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

**Hospital**

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

- An extended care facility; nursing home; place for rest; facility for care of the aged;



- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

### **Identification Card**

The latest card given to You showing Your Member numbers, the type coverage You have and the date coverage becomes effective.

### **Infertile or Infertility**

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

### **Injury**

Bodily harm from a non-occupational accident.

### **Inpatient**

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

### **Maintenance Medication**

A Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call Customer Service at the number on the back of Your Identification Card or check Our website at [www.bcbsga.com](http://www.bcbsga.com) for more details.

### **Maximum Allowed Amount**

The maximum amount that We will allow for Covered Services You receive. For more information, see the "General Provisions" section.

### **Medical Emergency**

"Emergency services," "emergency care," or "Medical Emergency" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe the his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunctions of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by BCBSHP.

### **Medical Facility**

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

### **Medical Necessity or Medically Necessary**

The program only pays the cost of Covered Services BCBSHP considers Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. A service is considered Medically Necessary if it is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;

- not provided solely for Your convenience or the convenience of the Physician, health care Provider or Hospital;
- not primarily Custodial Care; and
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

### **Member**

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

### **Mental Health and Substance Abuse**

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

### **Minimum Essential Coverage**

Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health, or benefits risk pool.

### **Network Hospital**

A Hospital located in Georgia which is a party to a written agreement with, and in a form approved by, BCBSHP to provide services to its Members; or a Hospital outside of Georgia which is a party to an agreement with another Blue Cross and Blue Shield HMO BLUE USA Plan.

### **Network Provider**

A Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services and supplies in the Service Area that has a Network Provider Contract with Us to provide Covered Services to Members. Also referred to as In-Network Provider.

### **Non-Covered Services**

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

### **Non-Participating Pharmacy**

A Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of BCBSHP at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You go to a Non-Participating Pharmacy.

### **Non-Preferred Provider**

A Hospital, Physician, Freestanding Ambulatory Facility, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have any Network a participating agreement with BCBSHP to provide services to its Members at the time services are rendered.

### **Out-of-Network Care**

Care received by a Member from an Out-of-Network Provider.

**Out-of-Network Provider**

A Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have a Network Provider Contract with BCBSHP at the time services are rendered.

**Out-of-Pocket Limit**

A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the "Schedule of Cost Shares and Benefits." Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the "Schedule of Cost Shares and Benefits" for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Cost Sharing is required unless otherwise specified in this Contract.

**Participating Hospital**

A Hospital located in Georgia which is a party to a written agreement with Us at the time the service for which You are seeking coverage is rendered, and in a form approved by, Blue Cross and Blue Shield of Georgia, Inc.; or a Hospital outside of Georgia which is a party to an agreement with another Blue Cross and Blue Shield Plan; or a Hospital outside Georgia located in an area not served by any Blue Cross and Blue Shield Plan.

**Participating Pharmacy**

A Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of BCBSHP at the time services are rendered. Participating Pharmacies may be based on a restricted Network, and may be different than the Network of Participating Pharmacies for other BCBSHP products. To find a Participating Pharmacy near You, call the Customer Service telephone number on the back of Your Identification card.

**Participating Provider**

A Hospital, Physician, Freestanding Ambulatory Facility (Surgical Center), Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies that has signed a Participating Agreement with Blue Cross and Blue Shield of Georgia, Inc. to accept its determination of usual, customary and reasonable Fees (UCR) or other payment provisions for Covered Services rendered to a Member who is his or her patient at the time the service is rendered. It is Your responsibility to determine if Your Provider is a Participating Provider with Us.

**Periodic Health Assessment**

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

**Pharmacy**

A place licensed by state law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a prescription from Your Doctor.

**Pharmacy and Therapeutics (P & T) Process**

A process to make clinically based recommendations that will help You access quality, low cost medicines within Your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

**Physical Therapy**

The care of disease or Injury by such methods as massage, hydrotherapy, heat or similar care. The service could be provided or prescribed, overseen and billed by the Physician, or given by a physiotherapist on an Inpatient basis on the order of a licensed Physician and billed by the Hospital.

**Physician**

Any licensed Doctor of Medicine (MD) legally entitled to practice medicine and perform surgery, and licensed Doctor of Osteopathy (DO) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (DPM) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (DDS) legally entitled to perform oral surgery. Optometrists and Clinical Psychologists (Ph.D.) are also considered covered Providers when acting within the scope of their licenses, and when rendering services covered under this Contract.

**Premium**

The amount that the Subscriber is required to pay BCBSHP to continue coverage.

**Prescription Drug (Drug)**

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes insulin, diabetic supplies, and syringes.

**Professional Ambulance Service**

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

**Provider**

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give You services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If You have a question about a Provider not described in this Contract please call the number on the back of Your Identification Card.

**Reimbursement Rate**

Eligible Charges calculated each year by BCBSHP for any contracted Provider. The payment rate will be applied to all Provider claims during the payment period.

**Respite Care**

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

**Self-Administered Drugs**

Drugs that are administered which do not require a medical professional to administer.

**Semiprivate Room**

A Hospital room which contains two or more beds.

**Skilled Convalescent Care**

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

**Skilled Nursing Facility**

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

**Specialty Drugs**

Drugs that are high-cost, injectable, infused, oral or inhaled Drugs that generally require close supervision and monitoring of their effect on the patient's Drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

**Specialty Pharmacy**

A Pharmacy which dispenses biotech Drugs for rare and chronic diseases via scheduled Drug delivery either to the Member's home or to a Physician's office. These Pharmacies also provide telephonic therapy management to ensure safety and compliance.

**Subscriber**

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

**Substance Abuse**

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

**Substance Abuse Rehabilitation**

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

**Technology Assessment Criteria**

Five criteria all investigative procedures must meet in order to be covered procedures under this Contract:

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

**Telehealth Services**

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

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

**Telemedicine Medical Service**

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

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

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

**Tier One Drugs**

This tier includes low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

**Tier Two Drugs**

This tier includes preferred Drugs considered Generic, single source Brand Drugs, or multi-source Brand Drugs.

**Tier Three Drugs**

This tier includes Drugs considered Generic, single source Brand Drugs, or multi-source Brand Drugs.

**Tier Four Drugs**

This tier contains high cost Drugs. This includes Drugs considered Generic, single source Brand Drugs, and multi-source Brand Drugs.

**Treatment**

Medical, surgical, and/or mental health services utilized by Providers to prevent, improve, or cure a disease or pathological condition.

**Utilization Review**

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



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