Individual Member Contract

BCBSHP Silver Core Pathway X HMO 5300

Individual Member Contract

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
3350 Peachtree Road, N.E., P.O. Box 4445
Atlanta, GA 30302

Right to Examine

If this Contract is presented 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 the Exchange. 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 Membership Ends (Termination)". Please note, however, that You are not covered until BCBSHP receives Your first payment and You are approved for coverage by the Exchange. All payments after the first one must be paid on or before the date they are due (BCBSHP calls this date the "due date").

Welcome to BCBSHP!

We are pleased that you have become a Member of Our health Plan, where it's Our mission to improve the health of the people We serve. We've designed this contract to give a clear description of Your benefits, as well as Our rules and procedures.

This contract explains many of the rights and duties between You and Us. It also describes how to get health care, what services are covered, and what part of the costs You will need to pay. Many parts of this contract are related. Therefore, reading just one or two sections may not give You a full understanding of Your coverage. You should read the whole contract to know the terms of Your coverage.

This contract, the application, and any amendments or riders attached shall constitute the entire contract under which Covered Services and supplies are provided by Us.

Many words used in the contract have special meanings (e.g., Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this contract You will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Blue Cross Blue Shield Healthcare Plan of Georgia. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If You have any questions about your Plan, please be sure to call Member Service at the number on the back of your Identification Card. Also be sure to check Our website, www.bcbsga.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

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

Jeffrey P. Fusile

President

How to obtain 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 Member Services call centers. Simply call the Member Services 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 Member Services. Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also 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 Member Services number.)

Identity Protection Services

Identity protection services are available with our BCBSHP health plans. To learn more about these services, please visit www.bcbsga.com/resources.

Contact Us

Member Services is available to explain policies and procedures, and answer questions regarding the availability of benefits.

For information and assistance, a Member may call or write BCBSHP.

The telephone number for Member Services is printed on the Member's Identification Card. The address is:

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
Member Services
3350 Peachtree Road, N.E.
Atlanta, GA 30302

Visit Us on-line
www.bcbsga.com

Home Office Address
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
Member Services
3350 Peachtree Road, N.E.
Atlanta, GA 30302

Hours of operation
Monday - Friday
8:00 a.m. to 5:00 p.m. EST

Conformity with 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.

Acknowledgement of Understanding

Subscriber hereby expressly acknowledges their understanding that this policy constitutes a contract solely between 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. Subscriber further acknowledges and agrees that it 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 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.

Delivery of Documents

We will provide an Identification Card and Contract for each Subscriber.

Benefit Program

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of Your benefits for Covered Services, which are listed in detail in the "What is Covered" section. A list of services that are not covered can be found in the "What is Not Covered (Exclusions)" section.

Services will only be Covered Services if rendered by In-Network Providers unless:

- The services are for Emergency Care, Urgent Care and Ambulance services related to an emergency for transportation to a Hospital; or
- The services are approved in advance by BCBSHP.

What will I pay?

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Certificate will allow for a Covered Service.

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

- In-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

For a detailed explanation of how Your Deductibles and Out-of-Pocket Annual Maximums are calculated, see the "Claims Payments" section. When you receive Covered Services from an Out-of-Network Provider, you may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

Plan Features

Deductible	**In-Network Member Pays**	**Out-of-Network Member Pays**
Individual	$5,300	Not Covered
Family	$10,600	Not Covered
The individual Deductible applies to each covered family member. No one person can contribute more than their individual Deductible amount. 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.		

Coinsurance	**In-Network Member Pays**	**Out-of-Network Member Pays**
Coinsurance Percentage (unless otherwise specified)	25% Coinsurance	Not Covered

Out-of-Pocket Limit	In-Network Member Pays	Out-of-Network Member Pays
Individual	$6,700	Not Covered
Family Includes Deductible, Copayments and Coinsurance	$13,400	Not Covered
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.		

If You receive services from an Out-of-Network Provider except in emergencies and out-of-area urgent care situations, You will be responsible for the charges for the services.

IMPORTANT: You are responsible for confirming that the Provider You are seeing or have been referred to see is a Network Provider for this plan. It is important to understand that BCBSHP has many contracting Providers who may not be part of the network of Providers that applies to this plan.

BCBSHP can help You find a Network Provider specific to Your plan by calling the number on the back of Your identification card.

Medical Services

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Allergy Injections	$0 Copayment 25% Coinsurance	Not Covered
Ambulance Services		
Emergency	$0 Copayment 25% Coinsurance	$0 Copayment 25% Coinsurance
Non-Emergency Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is Preauthorized by Us for use.	$0 Copayment 25% Coinsurance	Not Covered
Autism Services		
Applied Behavior Analysis Limited to a maximum of $30,000 Network and Out-of-Network combined per Benefit Period for Members through age six.	$0 Copayment 25% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
All other Covered Services for Autism	$0 Copayment 25% Coinsurance	Not Covered
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia)	Copayment/Coinsurance determined by service rendered	
Diabetic Management Program	$0 Copayment 25% Coinsurance	Not Covered
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered	
Diagnostic Services; Outpatient		
Diagnostic Laboratory and Pathology Services	$0 Copayment 25% Coinsurance	Not Covered
Diagnostic Imaging Services and Electronic Diagnostic Tests	$0 Copayment 25% Coinsurance	Not Covered
Advanced Imaging Services	$300 Copayment 50% Coinsurance	Not Covered
Doctor Office Visits		
Primary Care Physician (PCP) Office Visits. Retail Health Clinic Services, includes all Covered Services received at a Retail Health Clinic	Deductible does not apply; $35 Copayment 0% Coinsurance	Not Covered
Specialty Care Physician (SCP) Office Visits	$0 Copayment 25% Coinsurance	Not Covered
Other Office Services	$0 Copayment 25% Coinsurance	Not Covered
Durable Medical Equipment (medical supplies and equipment)	$0 Copayment 25% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Emergency Room Visits (Copayment is waived if admitted to the Hospital)	$0 Copayment 25% Coinsurance	$0 Copayment 25% Coinsurance
Home Health Care Limited to a maximum of 120 visits per Member, per calendar year.	$0 Copayment 25% Coinsurance	Not Covered
Hospice Care	$0 Copayment 25% Coinsurance	Not Covered
Hospital Services **Inpatient Facility** **Outpatient Facility** **Inpatient and Outpatient Professional Services**	$0 Copayment per admission 50% Coinsurance $0 Copayment 25% Coinsurance $0 Copayment 25% Coinsurance	Not Covered Not Covered Not Covered
Outpatient Therapy Services Outpatient Habilitative and Rehabilitative Therapy Services (limits on Physical, Occupational and Speech Therapy services listed below are not combined but separate based on determination of Habilitative service or Rehabilitative service) Chemotherapy and radiation Respiratory 20 visits per Member per calendar year Chiropractic 20 visits per Member per calendar year Occupational and physical therapy combined 20 visits each per Member per calendar year Speech therapy 20 visits per Member per calendar year Cardiac Rehabilitation 20 visits per Member per calendar year Therapy visit limits do not apply to autism services.	$0 Copayment 25% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Preventive Care Services Network services required by law are not subject to Deductible.	$0 Copayment 0% Coinsurance	Not Covered
Prosthetics – prosthetic devices, their repair, fitting, replacement and components Wigs are limited to the first one following cancer treatment, not to exceed 1 per Member, per calendar year.	$0 Copayment 25% Coinsurance	Not Covered
Skilled Nursing Facility Limited to a maximum of 60 visits per Member, per calendar year	$0 Copayment 25% Coinsurance	Not Covered
Surgery **Ambulatory Surgical Center**	$0 Copayment 25% Coinsurance	Not Covered
Temporomandibular and Craniomandibular Joint Treatment	Copayment/Coinsurance determined by service rendered	
Transplant Human Organ & Tissue 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	
Urgent Care Center	$50 Copayment 0% Coinsurance	$50 Copayment 0% Coinsurance

Prescription Drugs

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy. If you get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and you may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When you go to Level 1 In-Network Pharmacies, (also referred to as Core Pharmacies), you pay a lower Copayment / Coinsurance on Covered Services than when you go to other In-Network Providers.

Level 2 In-Network Pharmacies. When you go to Level 2 In-Network Pharmacies, (also referred to as Wrap Pharmacies), you pay a higher Copayment / Coinsurance on Covered Services than when you go to a Level 1 In-Network Pharmacy.

Retail Pharmacy Prescription Drugs	In-Network Member Pays		Out-of-Network Member Pays
	Level 1 Pharmacy	Level 2 Pharmacy	
Tier 1	Deductible does not apply; $10 Copayment 0% Coinsurance	Deductible does not apply; $20 Copayment 0% Coinsurance	Not Covered
Tier 2	Deductible does not apply; $40 Copayment 0% Coinsurance	Deductible does not apply; $50 Copayment 0% Coinsurance	Not Covered
Tier 3	$0 Copayment 40% Coinsurance	$0 Copayment 50% Coinsurance	Not Covered
Tier 4	$0 Copayment 40% Coinsurance	$0 Copayment 50% Coinsurance	Not Covered
Notes: Retail Pharmacy is limited to a 30-day supply per prescription. Specialty Drugs must be purchased from BCBSHP's Specialty Preferred Provider. Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).			

Mail Order Prescription Drugs	In-Network Member Pays	Out-of-Network Member Pays
Tier 1 (90-day supply)	Deductible does not apply; $25 Copayment 0% Coinsurance	Not Covered
Tier 2 (90-day supply)	Deductible does not apply; $120 Copayment 0% Coinsurance	Not Covered

Tier 3 (90-day supply)	$0 Copayment 40% Coinsurance	Not Covered
Tier 4 (30-day supply)	$0 Copayment 40% Coinsurance	Not Covered
Notes: Specialty Drugs must be purchased from BCBSHP's Specialty Preferred Provider and are limited to a 30-day supply. Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).		

Orally Administered Cancer Chemotherapy	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

The following pediatric dental services are covered for Members until the end of the month in which they turn 19.

Covered Dental Services, unless otherwise stated below, 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 Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Pediatric Dental Care	In-Network Member Pays	Out-of-Network Member Pays
Diagnostic and Preventive Services	0% Coinsurance	Not Covered
Basic Restorative Services	40% Coinsurance	Not Covered
Oral Surgery Services	50% Coinsurance	Not Covered
Endodontic Services	50% Coinsurance	Not Covered
Periodontal Services	50% Coinsurance	Not Covered
Major Restorative Services	50% Coinsurance	Not Covered
Prosthodontic Services	50% Coinsurance	Not Covered
Dentally Necessary Orthodontic Care Services	50% Coinsurance	Not Covered

Pediatric Vision Services

The following vision care services are covered for members until the end of the month in which they turn 19. To get the In-Network benefit you must use a Blue View Vision provider. Visit our website or call us at the number on your ID card if you need help finding a Blue View Vision provider.

Please see Pediatric Vision Care in the "What is Covered" section for a more information on pediatric vision services.

Covered vision services are **not** subject to the calendar year Deductible.

Covered Vision Services	In-Network Member Pays	Out-of-Network Reimbursement
Routine Eye Exam Covered once per Calendar Year per Member	$0 Copayment	Not Covered
Standard Plastic Lenses One set of lenses covered per Calendar Year per Member.		
Single Vision	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Progressive	$0 Copayment	Not Covered
Lenticular	$0 Copayment	Not Covered
Additional Lens Options Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from In-Network providers.		
Frames (formulary) One frame covered per Calendar Year per Member.	$0 Copayment	Not Covered
Contact Lenses (formulary) Elective or non-elective contact lenses are covered once per Calendar Year per Member.		
Elective (conventional and disposable)	$0 Copayment	Not Covered
Non-Elective	$0 Copayment	Not Covered
Important Note: Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Covered Vision Services	In-Network Member Pays	Out-of-Network Reimbursement
Low Vision Low vision benefits are only available when received from Blue View Vision providers.		
Comprehensive Low Vision Exam Covered once every two Calendar Years per Member	$0 Copayment	Not Covered
Optical/non-optical aids and supplemental testing. Limited to one occurrence of either optical/non-optical aids or supplemental testing every two Calendar Years per Member.	$0 Copayment	Not Covered

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

HOW YOUR COVERAGE WORKS

Network Services and Benefits

If Your care is rendered by a Network Primary Care Physician, Network 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 Network Primary Care Physician, Network 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 "If You Have a Complaint or an Appeal" section of this Contract.

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

Network Specialty Care Physicians are Network Providers who provide specialty medical services not normally provided by a Network 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

Your health care plan does not cover benefits for services received from Non-Network Providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care services; or
- Authorized by Us.

Dental Providers

You must select a participating dentist to receive dental benefits. Please call Our Member Services department at (800) 627-0004 for help in finding a participating dentist or visit Our website at 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.

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, which lists the Doctors, Providers, and facilities that participate in this plan's network.
- Call Member Services 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 Member Services 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 have any questions about Covered Services, call Us at the telephone number listed on the back of Your Identification Card.

Continuity of Care

If Your In-Network Provider leaves our network because we have terminated their contract without cause, and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still receive In-Network benefits. "Active treatment" includes:

1. An ongoing course of treatment for a life-threatening condition.
2. An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits).
3. The second or third trimester of pregnancy and through the postpartum period.
4. An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes. An "ongoing course of treatment" includes treatments for mental health and substance use disorders.

In these cases, you may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details. Any decision by Us regarding a request for Continuity of Care is subject to the Appeals Process.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Contract. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. BCBSHP may decide a service that was asked for is not Medically Necessary if You have not tried other treatments that are more cost effective.

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

Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. 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 Service 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.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
    - **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain Services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.

      For admissions following Emergency Care, 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 Pre-Service Review request for a benefit coverage determination for a 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 or is Experimental/Investigative as those terms are defined in this Contract.
- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. Post-service reviews are performed when a service, treatment or admission did not need Precertification or did not have a Predetermination review performed. Post-service reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Who is Responsible for Precertification

Typically, Network Providers know which services need Precertification and will get any Precertification when needed or ask for a Predetermination, even though it is not required. 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 ("requesting Provider") will get in touch with Us to ask for a Precertification or Predetermination review. However, You may request a Precertification or Predetermination, or 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. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsible Party	Comments
In-Network	Provider	The Provider must get Precertification when required
Out-of-Network	Member	Member has no benefit coverage for an Out-of-Network Provider unless: • The Member gets approval to use a(n) Out-of-Network Provider before the service is given, or • The Member requires an Emergency care admission (see note below). Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary or Emergency Care.
BlueCard Provider	Member **(Except for Inpatient Admissions)**	Member has no benefit coverage for a BlueCard® Provider unless • The Member gets approval to use a BlueCard® Provider before the service is given, or • The Member requires an Emergency care admission (see note below). If these are true, then • The Member must get Precertification when required (call Member Services). • Member may be financially responsible

		for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary, Emergency Care or any charges in excess of the Maximum Allowed Amount. • **BlueCard Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For Emergency Care 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.		

How Decisions are Made

We will use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

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

If You are not satisfied with Our decision under this section, please refer to the "If You Have a Complaint or an Appeal" section to see what rights may be available to You.

Decision and Notice 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.

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Concurrent/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.
Urgent Concurrent/Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request

Urgent Concurrent/Continued Stay Review 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
Non-Urgent Concurrent/Continued Stay Review	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, We will tell the requesting Provider of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.

We will notify You and Your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

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

We may also 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 find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line pre-certification list, or contacting the Member Services number on the back of Your ID 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.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) helps 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 Case 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.

WHAT IS COVERED

This section describes the Covered Services available under this Contract. Covered Services are subject to all the terms and conditions listed in this Contract, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements.

Please read the following sections of this contract for more information about the covered services described in this section:

- “Schedule of Cost Shares and Benefits” – for amounts you need to pay and benefit limits
- “Requesting Approval for Benefits” – for details on selecting providers and services that require prior authorization
- “What is not covered (Exclusions)” – for details on services that are not covered

Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have inpatient surgery, benefits for your Hospital stay will be described under "Hospital Services; Inpatient Hospital Care" and benefits for your Doctor’s services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many Covered Services can be received in several settings, including a Doctor’s office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay.

Medical Services

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services 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 an accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Out-of-Network Hospital to an In-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.

Out-of-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 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 Plan. The 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 types 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.

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.

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 of Health and Human Services 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. The peer review requirement shall not be applicable to cancer Clinical Trials provided by i-iii below.
      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. Clinical Trial Programs for Treatment of Children's Cancer. Covered Services include 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).

Your Plan may require you to use an In-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.

All requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Dental services for Accidental Injury

Benefits are available 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 an 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.

We do not consider Injury as a result of chewing or biting to be an Accidental injury, unless the injury results from a mental or medical condition therefore, We do not cover dental services for this type of care.

Anesthesia services for certain dental patients in a 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.

Diabetes Services

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self-Management Training is covered for an individual with insulin dependent diabetes, noninsulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment and Appliances". Screenings for gestational diabetes are covered under "Preventive Care".

Diagnostic Services Outpatient

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
- QCT Bone Densitometry
- Diagnostic CT Colonography

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

Doctor (Physician) Visits

Covered Services include:

Office Visits for medical care (including second opinions) to examine, diagnose, and treat an illness or injury.

After Hours Care for medical 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.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care Services" benefit described later in this section.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Allergy Services for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Online Visits when available in your area. Covered 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. For Mental Health and Substance Abuse Online Visits, see the "Mental Health and Substance Abuse Services" section.

Telehealth Covered Services that are appropriately provided by a telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Contract. Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail. If you have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of your identification card.

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 Allowed Amounts for the service provided. The patient (Member) is subject to the applicable Deductible and Coinsurance based upon their benefits.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition", means a medical or behavioral health 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 not getting immediate medical care could result in: (a) placing the patient's health or the health of another person in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions.

Emergency Care means a medical or behavioral health exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Stabilize, with respect to an emergency medical condition, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to

deliver (including the placenta), if there is inadequate time to affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will not be available unless we agree to cover them as an Authorized Service.

Habilitative Services

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.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Visits by a licensed health care professional, including nursing services by an R.N. or L.P.N, a therapist, or home health aide.
- Infusion Therapy; refer to Other Therapy Services, later in this section for more information.
- Medical / social services.
- Diagnostic services.
- Nutritional guidance.
- Training of the patient and/or family/caregiver.
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Medical supplies.
- Durable medical equipment.
- Therapy Services (except for Manipulation Therapy, which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.

A Home Health Care visit must consist of 4 hours of care.

Hospice Care

Hospice care is a coordinated plan of home, inpatient and/or outpatient care that provides palliative, supportive medical, psychological, psychosocial, and other health services to terminally ill patients.

Covered services and supplies are those 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.

- 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 and 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 6 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 certificate, are provided as set forth in other parts of this certificate.

Hospital Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting. Benefits for room, board, nursing and ancillary services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.
- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Outpatient Hospital Care

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Center,
- Mental Health and Substance Abuse Facility,
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when Medically Necessary, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Maternity services incurred prior to Your Effective Date are not covered.

Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services; and,
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

Note: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section

(C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Abortion Services

Benefits for abortions 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).

Infertility Services

Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Medical Supplies, Durable Medical Equipment and Appliances

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs, except when damage is due to neglect. Benefits also include supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- Breast prosthesis (whether internal or external) after a mastectomy, as required by law;
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care; or,
- Restoration prosthesis (composite facial prosthesis).
- Wigs needed after cancer treatment.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Diabetic Equipment and Supplies

Your plan includes coverage for diabetic equipment and supplies (insulin pump, blood glucose monitor, lancets and test strips, etc.)

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Mental Health and Substance Abuse Services

Benefits are available for the diagnosis, crisis intervention and treatment of acute Mental Disorders and Substance Abuse Conditions. Mental Health and Substance Abuse is 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. For the purposes of this section the Joint Commission is abbreviated as JCAHO and the Commission on Accreditation of Rehabilitation Facilities is abbreviated as CARF.

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 in-home and office visits and treatment in an outpatient department of a Hospital or JCAHO or CARF-accredited outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- Online Visits when available in your area. Covered 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.
- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center accredited by JCAHO or CARF. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- 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.

Preventive Care Services

Preventive care include screenings and other services for adults and children.

All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem, may be covered under the "Diagnostic Services" benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
   - Breast cancer,
   - Cervical cancer,
   - High blood pressure,
   - Type 2 Diabetes Mellitus,
   - Cholesterol,
   - Child or adult obesity; or,
   - Colorectal cancer,
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration, including:
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
   - Contraceptive coverage includes generic drugs and single-source brand name 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 name drugs will be covered, as preventive care benefits when medically necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail order) Pharmacy".
   - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per calendar year or as required by law.
   - Gestational diabetes screening.

5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

    - Counseling
    - Prescription Drugs
    - Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.
    - Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

    - Aspirin
    - Folic acid supplement
    - Vitamin D supplement
    - Bowel preparations

Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's web sites:

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

Rehabilitative Services

Health care services that help you keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including surgeries performed in a doctor's office or an ambulatory surgical center. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Oral Surgery

Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part;
- Oral / surgical correction of accidental injuries;
- Treatment of non-dental lesions, such as removal of tumors and biopsies;
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include 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.

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
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth (braces), repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

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. Also covered is 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

Therapy Services Outpatient

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services at spas or health clubs.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.

- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents.
- **Chiropractic Care** - Services performed by a Physician, a registered physical therapist (RPT), a licensed occupational therapist (O.T.) or a licensed chiropractor (D.C.) 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.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility or doctor's office. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). 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.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

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.

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 Allowed 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. 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. Please call us to find out which Hospitals are In-Network Transplant Providers. Contact the Member Services 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.

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.

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.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees). Benefits for urgent care may include:

- X-ray services;
- Care for broken bones
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Prescription Drugs

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility and are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Benefits for Drugs that you inject or get through your Pharmacy benefit (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan 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 eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria which are called drug edits, may include requirements regarding one or more of the following:

- quantity, dose, and frequency of administration;
- specific clinical criteria (including but not limited to requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- specific provider qualifications (including but not limited to REMS certification (Risk, Evaluation and Mitigation Strategies));
- step therapy requiring one drug or a drug regimen or another treatment be used prior to use of another drug or drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another;
- Use of an BCBSHP Prescription Drug List (a formulary developed by BCBSHP which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness).

Precertification

Precertification may be required for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of our decision to both you and your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section "Requesting Approval for Benefits" for more details.

If precertification is denied you have the right to file a Grievance as outlined in the "If you have a Complaint or an Appeal" section of this Contract.

Designated Pharmacy Provider

BCBSHP, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care Coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

We may also require you to use a Designated Pharmacy Provider to obtain Specialty Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. BCBSHP may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in our discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, You will not have coverage for that Prescription Drug.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Identification Card or check our website at www.bcbsga.com.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also 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 Order) 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.

Note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you by a medical provider in a medical setting (e.g., doctor's office visit, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization

Prescribing Providers must obtain prior authorization for drug edits in order for you to get benefits for certain Drugs. At times, your Provider will initiate a Prior Authorization on your behalf before your Pharmacy fills your prescription. At other times, the Pharmacy may make you or your Provider aware that a Prior Authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- quantity, dose, and frequency of administration;
- specific clinical criteria (including but not limited to requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- specific provider qualifications (including but not limited to REMS certification (Risk, Evaluation and Mitigation Strategies));

- step therapy requiring one drug or a drug regimen or another treatment be used prior to use of another drug or drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another;
- use of a Prescription Drug List (as described below).

You or your provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of your Identification Card or check our website at www.bcbsga.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

BCBSHP may, from time to time, waive, enhance, change or end certain prior authorization and/or alternate benefits, if in our sole discretion; such change furthers the provision of cost effective, value based and/or quality services.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the "If you have a Complaint or an Appeal" section of this Contract.

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.
- Flu Shots (including administration).

Where You Can Get Prescription Drugs

In-Network Pharmacy

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. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will 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.

Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, we may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network Pharmacy. We will contact you if we determine that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies we offer within 31 days, we will select a single In-Network Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "If you have a Complaint or an Appeal" section of this Contract.

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy. If you get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and you may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When you go to Level 1 In-Network Pharmacies, (also referred to as Core Pharmacies), you pay a lower Copayment / Coinsurance on Covered Services than when you go to other In-Network Providers.

Level 2 In-Network Pharmacies. When you go to Level 2 In-Network Pharmacies, (also referred to as Wrap Pharmacies), you pay a higher Copayment / Coinsurance on Covered Services than when you go to a Level 1 In-Network Pharmacy.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered 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. We may require you or your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

When you use the PBM's Specialty Pharmacy its patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of your Identification Card or check our website at www.bcbsga.com.

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.

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 member services representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Maintenance Medication

A Maintenance Medication is 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 the Prescription Drug you

are taking is a Maintenance Medication, please call Member Services at the number on the back of your Identification Card or check our website at www.bcbsga.com for more details.

If you are taking a Maintenance Medication, you may get the first 30 day supply and one 30 day refill of the same Maintenance Medication at your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy 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 at 888-772-5188 or by visiting our website at www.bcbsga.com.

When using Home Delivery, 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 call Member Services toll-free at 1-800-281-5524.

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 Member Services department at 1-866-274-6825 for availability of the Drug or medication.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy.

- **Tier 1** Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- **Tier 2** Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 3** Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 4** Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., oral, injection, 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. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

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 refer to our website at www.bcbsga.com.

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.

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.

Drug Utilization Review

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.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we

may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Member Services at the number on the back of your Identification Card.

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.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone 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 Specialty 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 Member Services number on your member ID card or log on to the member website at 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.

Pediatric Dental Care

Your Dental Benefits. Dental care treatment decisions are made by you and your dentist. We cover treatment based on what benefits you have, not whether the care is medically or dentally necessary. The only exception is when you get orthodontic care — we do review those services to make sure they're appropriate.

Pretreatment Estimates. When you need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it's best to go over a care or treatment plan with your dentist beforehand. It should include a "pretreatment estimate" so you know what it will cost.

You or your dentist can send us the pretreatment estimate to get an idea of how much of the cost your benefits will cover. Then you can work with your dentist to make financial arrangements, before you start treatment.

Pediatric Dental Essential Health Benefits. The following dental care services are covered for members until the end of the month in which they turn 19. All covered services are subject to the terms, limitations, and exclusions of this Contract. See the Schedule of Cost Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

Oral Exams. Two oral exams are covered each calendar year.

Radiographs (X-rays): Here are ones that are covered:

- Bitewings – 2 sets per calendar year.
- Full mouth (also called complete series) – 1 time per 60 month period.
- Panoramic – 1 time per 60 months.
- Periapicals, occlusals, and extraoral films are also covered.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per calendar year. Paid as child prophylaxis if member is 13 or younger, and adult prophylaxis starting at age 14.

Fluoride Treatment (topical application or fluoride varnish). Covered 2 times per 12 month period.

Sealants. Covered once per tooth every 3 years.

Space Maintainers and Recement Space Maintainers

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Fillings (restorations). Fillings are covered when placed on primary or permanent teeth. There are two kinds of fillings covered under this plan:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If you choose to have a composite resin filling placed on a back tooth, we will pay up to the maximum allowed amount for an amalgam filling. You will be responsible to pay for the difference, if the dentist charges more, plus any applicable deductible or coinsurance.

Periodontal Maintenance. This procedure includes periodontal evaluation, removing bacteria from the gum pocket areas, measuring the gum pocket areas, and scaling and polishing of the teeth. Any combination of this procedure and dental cleanings (see Diagnostic and Preventive Services above) is covered 4 times per 12 months.

Endodontic Therapy on Primary Teeth

- Pulpal therapy
- Therapeutic pulpotomy

Periodontal Scaling and Root Planing. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per quadrant per 24 months.

Resin Based Composite Crown. Covered 1 per 5 years for primary teeth only.

Pre-fabricated or Stainless Steel Crown. Covered 1 time per 5 year period for members through the age of 14.

Pin Retention. Covered 1 time per 5 years.

Partial pulpotomy for apexogenesis. Covered on permanent teeth only

Endodontic Services

Endodontic Therapy. The following will be covered for permanent teeth only:

- Root canal therapy.
- Root canal retreatment.

Other Endodontic Treatments

- Apexification
- Apicoectomy
- Root amputation
- Hemisection
- Retrograde filling

Periodontal Services

Complex Surgical Periodontal Care. These services are surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Only one of the below services is covered per single tooth or multiple teeth in the same quadrant per 36 month period. Covered for permanent teeth only.

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap
- Osseous surgery
- Bone replacement graft
- Pedicle soft tissue graft. Not subject to the benefit frequency limitation stated above.
- Free soft tissue graft
- Subepithelial connective tissue graft. Not subject to the benefit frequency limitation stated above.
- Soft tissue allograft
- Combined connective tissue and double pedicle graft
- Distal/proximal wedge. Covered on natural teeth only.

Oral Surgery Services

Basic Extractions

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

General Anesthesia

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered when given with a complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist that is certified in their profession to give anesthesia services.

Major Restorative Services

Gold foil restorations. Gold foil restorations are covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same maximum allowed amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable deductible and coinsurance.

Inlays. Inlays are covered at the same frequency as an amalgam filling. Inlays will be paid up to the same maximum allowed amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable deductible and coinsurance.

Onlays or Permanent Crowns. Covered 1 time per 5 year period. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the maximum allowed amount for a porcelain to noble metal crown. If you choose to have another type of crown, you're responsible to pay for the difference plus any applicable deductible and coinsurance.

Recement an Inlay, Onlay or Crown. Covered 6 months after initial placement.

Inlay, Onlay or Crown Repair

Implant Crowns. See the implant procedures description under Prosthodontic Services.

Restorative Cast Post and Core Build Up. Includes 1 post per tooth and 1 pin per surface. Covered 1 time per 60 months. Covered only if needed to retain an indirectly fabricated restoration (such as a crown) due to extensive loss of tooth structure due to decay or fracture.

Prefabricated Post and Core (in addition to crown). Covered 1 time per tooth every 60 months.

Prosthodontic Services

Dentures and Partials (removable prosthodontic services). Covered 1 time per 5 years for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 5 years have passed and it cannot be repaired or adjusted.

Bridges (fixed prosthodontic services). Covered 1 time per 5 years for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted. In order for the bridge to be covered:

- A natural healthy and sound tooth is present to service as the anterior and posterior retainer.
- There are no other missing teeth in the same arch that have been replaced with a removable partial denture.
- And none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this plan in the last 5 years.

The plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the plan may cover a partial denture instead of the bridge. If you still choose to get the bridge, you will be responsible to pay the difference in cost, plus any applicable deductible and coinsurance.

Tissue Conditioning

Reline and Rebase. Covered 1 time per 36 months as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance.

Repairs and Replacement of Broken Clasps

Replacement of Broken Artificial Teeth. Covered as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance and the narrative from the treating dentist supports the service.

Denture Adjustments. Covered once 6 months has passed from the initial placement of the denture.

Partial and Bridge Adjustments. Covered once 6 months have passed from the initial placement of the partial or bridge.

Recementation of Bridge (fixed prosthetic). Covered once per 5 years.

Single Tooth Implant Body, Abutment and Crown. Covered 1 time 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. It's recommended that you get a pretreatment estimate, so you fully understand the treatment and cost before having implant services done.

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your dental provider about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. You or your dental provider should send it to us so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontic Care. This plan will only cover orthodontic care that is dentally necessary — at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with your biting function
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of your mouth when you bite
- The position of your jaw or teeth impairs your ability to bite or chew
- On an objective, professional orthodontic severity index, your condition scores consistent with needing orthodontic care

What Orthodontic Care Includes. Orthodontic care may include the following types of treatment:

- Pre-Orthodontic Treatment Exams. Periodic visits with your dentist to establish when orthodontic treatment should begin.
- Periodic Orthodontic Treatment Visits.
- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office visits.
- Removable Appliance Therapy. Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy. Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures. Surgical procedures give for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

How We Pay for Orthodontic Care. Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of your treatment. In order for us to continue to pay for your orthodontic care you must have continuous coverage under this Contract.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental provider should submit the necessary forms telling us when your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this Contract ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this Contract, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under this

Contract. We will not pay for any portion of your treatment that was given before your effective date under this Contract.

What Orthodontic Care Does NOT Include. The following is not covered as part of your orthodontic treatment:

- Monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this Contract.
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Pediatric Vision Care

These vision care services are covered for members until the end of the month in which they turn 19. To get in-network benefits, use a Blue View Vision eye care provider. For help finding one, try "Find a Doctor" on our website, or call us at the number on your ID card.

Routine Eye Exam

This contract covers a complete routine eye exam with dilation as needed. The exam is used to check all aspects of your vision.

Eyeglass Lenses

Standard plastic (CR39) eyeglass lenses up to 55mm are covered, whether they're single vision, bifocal, trifocal (FT 25-28), progressive or lenticular.

There are a number of additional covered lens options that are available through your Blue View Vision provider. See the Schedule of Cost Shares and Benefits for the list of covered lens options.

Frames

Your Blue View Vision provider will have a collection of frames for you to choose from. They can tell you which frames are included at no extra charge — and which ones will cost you more.

Contact Lenses

Each year, you get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options in a given year. Your Blue View Vision provider will have a collection of contact lenses for you to choose from. They can tell you which contacts are included at no extra charge – and which ones will cost you more.

Elective contact lenses are ones you choose for comfort or appearance.

Non-elective contact lenses are ones prescribed for certain eye 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
- For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Note: We will not pay for non-elective contact lenses for any member who's had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is when you have a significant loss of vision, but not total blindness. Your plan covers services for this condition when you go to a Blue View Vision eye care provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

WHAT IS NOT COVERED (EXCLUSIONS)

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

We will not allow benefits for any of the following services, supplies, situations, or related expenses:

Services by Out-of-Network Providers unless:

- The services are for Emergency Care, Urgent Care and Ambulance services related to an emergency for transportation to a Hospital; or
- The services are approved in advance by BCBSHP.

Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Ambulance services related to an emergency for transportation to a Hospital.

Medical Services

Your Medical benefits do not cover:

Abortions. We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result 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.

Affiliated Providers. Services 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.

After Hours or Holidays Charges. Additional charges beyond the Maximum Allowed Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

Allergy Tests/Treatment. The following services, supplies or care are not covered:

- IgE RAST tests unless intradermal tests are contraindicated.
- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
- Food allergy test panels (including SAGE food allergy panels).
- 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.
- 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.
- Antigen leukocyte cellular antibody test (ALCAT); or
- Cytotoxic test; or
- HEMOCODE Food Tolerance System; or
- IgG food sensitivity test; or
- Immuno Blood Print test; or
- Leukocyte histamine release test (LHRT).

Alternative/Complementary Medicine. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis,

bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

Ambulance. Usage is not covered 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:

- A Physician's office or clinic;
- 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.

Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the "What's Covered" section unless otherwise required by law.

Armed Forces/War. 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.

Artificial/Mechanical Devices - Heart Condition. 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 ventricular assist devices used as a bridge to transplantation, or as a permanent alternative to heart transplantation, or the total artificial heart if the request meets Anthem Medical Policy criteria.

Bariatric Surgery. 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 one 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.

Before Effective Date or After Termination Date. Charges for care You get before Your Effective Date or after Your coverage ends, except as written in this Agreement.

Charges Over the Maximum Allowed Amount. Charges over the Maximum Allowed Amount for Covered Services.

Clinical Trials. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

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

Complications of Non-Covered Services Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

Complications Resulting from Experimental/Investigative or non Medically Necessary Services or Treatment. 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/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

Corrective Eye Surgery. 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.

Cosmetic Services. Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

Counseling Services. Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

Court Ordered Care. For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

Custodial Care, Services/Care Other Facilities. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Custodial Care, convalescent care or rest cures.
- 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.
- 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.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
- 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.

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Braces. For Dental braces unless specifically stated as a Covered Service.

Dental Implants. For Dental implants unless specifically stated as a Covered Service.

Dental Treatment. 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:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.

Dental X Rays, Supplies & Appliances. 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:

- Transplant preparation.
- Initiation of immunosuppresives.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

Drugs Prescribed by Providers lacking qualifications/certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications as determined by BCBSHP.

Drugs Over Quantity or Age Limits. Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.

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.

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.)

Education/Training. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

Exams - Research Screenings. For examinations relating to research screenings.

Experimental/Investigative. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/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/Investigative.

Eyeglasses/Contact Lenses. 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.

Family/Self. 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.

Feet - Surgical Treatment. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

Foot Care – Routine. 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
- applying skin creams in order to maintain skin tone
- other services that are performed when there is not a localized illness, injury or symptom involving the foot

Gene Therapy. Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Government Coverage. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

Gynecomastia. For surgical treatment of gynecomastia.

Hair loss or growth treatment. Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Health Club Memberships and Fitness Services. Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Hearing Aids. For hearing aids or examinations for prescribing or fitting them, except as specified in the "What is Covered" section of this Contract. This exclusion does not apply to cochlear implants.

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

Hospice (Care). We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed in the "What is Covered" section or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- 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.
- Services provided by volunteers.

Human Growth Hormone. Human Growth Hormone.

Hyperhydrosis. For treatment of hyperhydrosis (excessive sweating).

Impotency. For services and supplies related 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.

Incarceration. 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.

Infertility Testing and Treatment. Covered services do not include assisted reproductive technologies (ART) or the diagnostic tests and drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Maintenance Therapy. 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.

Manipulation Therapy – Home. For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Health Care Services benefit.

Medical Equipment, Devices, and Supplies. We do not provide benefits for supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.

Medicare Benefits. (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 and B, except, as specified elsewhere in this Subscriber Agreement or as otherwise prohibited by federal law. 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.

Missed/Cancelled Appointments. For missed or cancelled appointments.

No legal obligation to pay. For which you have no legal obligation to pay in the absence of this or like coverage.

Non Authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

Non Emergency Care Received in Emergency Room. For care received in an Emergency Room that is not Emergency Care, except as specified in the "What is Covered" section. This includes, but is not limited to, suture removal in an Emergency Room.

Not Medically Necessary. Any services or supplies which are not Medically Necessary.

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as provided in the "What is Covered" section or as required by law. This exclusion includes, but 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.

Off label use. Off label use, unless we must cover the use by law or if we approve it.

Orthodontic Services. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Monthly treatment visits that are inclusive of treatment cost;
- 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).

Outdoor Treatment Programs and/or Wilderness Programs.

Over the Counter. 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 the "What is Covered" section or as required by law.

Personal Hygiene, Environmental Control or Convenience Items. For personal hygiene, environmental control, or convenience items including but not limited to:

- Air conditioners, humidifiers, air purifiers;

- 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.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

Physical exams and immunizations - other purposes. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

Physician Stand-by Charges. For stand-by charges of a Physician.

Private Duty Nursing. For Private Duty Nursing Services unless specified in the "What is Covered" section.

Provider Services. You get from Providers that are not licensed by law to provide Covered Services, as defined in this Certificate. Examples of such Providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Provider Type. Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

Reconstructive Services. Reconstructive services except as specifically stated in the "What is Covered" section, or as required by law.

Regression Prevention. For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable, except as specified in the "What is Covered" section.

Residential Accommodations to treat behavioral health conditions, except when provided in a Hospital or Residential Treatment Center.

Reversal of Sterilization. For reversal of sterilization.

Riot, Nuclear Explosion. 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.

Self-Help. Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.

Shock Wave Treatment. Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

Spinal Decompression Devices. Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

Surrogate Pregnancy. 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).

Teeth - Congenital Anomaly. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in Dental Services in the "What is Covered" section or as required by law.

Teeth, Jawbone, Gums. 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.

Therapy – Other. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Gastric electrical stimulation;
- Hippotherapy;
- Intestinal rehabilitation therapy;
- Prolotherapy;
- Recreational therapy;
- Sensory integration therapy (SIT).

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Exclusions. Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care;
- Meals;
- Mileage within the medical transplant facility city;
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
- 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.

Unlisted services. Services not specifically stated in this Agreement as Covered Services unless a covered essential health benefit.

Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

Vision Orthoptic Training. For vision orthoptic training. This exclusion does not apply to Members through the end of the month in which the Member turns age 19.

Waived Copayment, Coinsurance, or Deductible. For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

Weight Loss Programs. For 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 commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Wigs, Hair Transplants, or Hairpieces. Hair transplants, hairpieces or wigs, wig maintenance, or prescriptions or medications related to hair growth, except as specified in the “What is Covered” section.

Workers Compensation. 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.

Prescription Drugs

Your Prescription Drug benefits do not cover:

- Administration Charges for the administration of any Drug except for covered immunizations as approved by us or the Pharmacy Benefits Manger (PBM).
- Clinically-Equivalent Alternatives Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.bcbsga.com.
- Drugs Prescribed by Providers Lacking Qualifications/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications as determined by BCBSHP.
- Compound Drugs.
- 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.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- 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.
- 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.
- 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.
- 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.
- Gene Therapy as well as any Drugs, procedures, health care services related to it that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
- Services or Supplies from Family Members. Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, Domestic Partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs. Refills of lost or stolen Drugs.
- 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.
- Drugs not approved by the FDA.
- Off label use. Off label use, unless we must cover the use by law or if We, or the PBM, approve it.
- Onchomycosis Drugs. Drugs for Onchomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items. Drugs, devices and products, or 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.

- Sexual Dysfunction Drugs. Drugs to treat sexual or erectile problems.
- Syringes. Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs. Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

Pediatric Dental Care

Your dental care services do not include services incurred for or in connection with any of the items below:

- Dental Care for members age 19 and older, unless covered by the medical benefits of this contract.
- 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 do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this contract).
- Services of anesthesiologist, unless required by law.
- Anesthesia Services, (such as intravenous or non-intravenous conscious sedation and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case presentations, office visits, consultations.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the contract.
- Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this contract.
- Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this contract.
- Separate services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration that is billed separately from a restoration procedure (such as a filling).
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.
- Repair or replacement of lost or broken appliances.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

- For dental services received prior to the effective date of this contract or received after the coverage under this contract has ended.
- Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this contract.
- Occlusal or athletic mouth guards.
- Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
- 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.

Pediatric Vision Care

Your vision care services do not include services incurred for or in connection with any of the items below:

- Vision care for members age 19 and older, unless covered by the medical benefits of this contract.
- 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.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse or Domestic Partner , child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- Visual therapy, such as orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, except as specified in the "What is Covered" section of this contract.
- Lost or broken lenses or frames, unless the member has reached their normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this contract.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this contract.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

CLAIMS PAYMENTS

This section describes how your claims are administered, explains the cost-sharing features of your plan, and outlines other important provisions. The specific cost sharing features, and the applicable benefit percentages and/or limitations, are outlined in the "Schedule of Cost Shares and Benefits" section.

We consider covered services to be incurred on the date a service is provided. This is important because you must be actively enrolled on the date the service is provided.

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.

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).

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.

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.

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.

Maximum Allowed Amount

General

This provision describes how We determine the amount of reimbursement for Covered Services.

Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on Your Contract Maximum Allowed Amount for the Covered Service that You receive. Please also see “Inter-Plan Programs” provision for additional information.

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

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

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.

Generally, services received from an Out-of-Network Provider under this Contract are not covered except for Emergency care, or when services have been previously authorized by Us. When You receive Covered Services from an Out-of-Network Provider either in an Emergency or when services have been previously authorized, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When You receive Covered Services from 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 means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same doctor 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 an In-Network or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for Your Contract is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for 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 Member Services for help in finding an In-Network Provider or visit Our website www.bcbsga.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. If You use an Out-of-Network Provider, Your entire claim will be denied except for Emergency care, or unless the services were previously authorized by Us.

For Covered Services You receive in an Emergency or if previously authorized from an Out-of-Network Provider, the Maximum Allowed Amount for this Contract will be one of the following as determined by Us:

1. An amount based on Our Out-of-Network fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with 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; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with Us are also considered Out-of-Network. For this Contract the Maximum Allowed Amount 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.

For services rendered outside BCBSHP’s Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross and/or Blue Shield plan’s nonparticipating provider fee schedule/rate or the pricing arrangements required by applicable State or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the BCBSHP Service Area, or a special negotiated price.

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

Member Services is also available to assist You in determining Your Contract Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for Us to assist You, You will need to

obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your out of pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by Us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

We will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your Contract 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 In-Network Cost-Sharing amount when You use an Out-of-Network Provider. For example, if You go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, You will pay the In-Network Cost-Share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Contract Cost-Share amounts; see Your "Schedule of Cost Shares and Benefits" for Your applicable amounts.

Example: Your Contract has a Coinsurance Cost-Share of 20% for In-Network services after Deductible has been met.

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, We may authorize the In-Network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may authorize the In-Network Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact Us until after the

Covered Service is rendered. If We authorize an In-Network Cost-Share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for authorized services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Contract Cost-Share amounts; see Your "Schedule of Cost Shares and Benefits" for Your applicable amounts.

Example:

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

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

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

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

What Your Coverage Covers

Percentage Payable In-Network

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 Allowed Amount during the remainder of the calendar year.

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 Amounts for Covered Services is applied to his or her individual Deductible. Once two or more family Members' Maximum Allowed Amounts 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 or her individual Deductible to the family Deductible.

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 amounts 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 Cost-Sharing will be required for the remainder of the Calendar Year.

Credit toward Deductible

Your plan includes a Deductible carry-over provision. This means that any amounts applied to Your calendar year Deductible during the last three months of the calendar year will be applied towards the next calendar year Deductible. This provision does not apply to vision calendar year Deductible.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "BCBSHP Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the BCBSHP Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers. BCBSHP covers only limited healthcare services received outside of the BCBSHP Service Area. For example, Emergency or Urgent Care obtained outside the BCBSHP Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by BCBSHP.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard Program, when you receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the BCBSHP Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

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

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 that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard Program

If you receive Covered Services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSHP through average pricing or fee schedule adjustments. Additional information is available upon request.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside Our Service Area

1. **Allowed Amounts and Member Liability Calculation**

   When Covered Services are provided outside of BCBSHP's Service Area by non-participating providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible, copayment or coinsurance will be based on that allowed amount Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. **Exceptions**

   In certain situations, We may use other pricing methods, such as billed charges the pricing we would use if the healthcare services had been obtained within the BCBSHP Service Area, or a special negotiated price to determine the amount We will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment We make for the Covered Services as set forth in this paragraph.

E. BlueCard Worldwide® Program

If you plan to travel outside the United States, call Member Services to find out your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. The plan only covers Emergency, including ambulance, and Urgent Care outside of 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 804-673-1177.

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.

How Claims are Paid with BlueCard Worldwide

In most cases, when you arrange inpatient hospital care with BlueCard Worldwide, 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 typically 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.bluecardworldwide.com.

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

Claims Review for Fraud, Waste and Abuse

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 Certificate from non-participating or out-of network Providers could be balanced billed by the non-participating out-of-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.

IF YOU HAVE A COMPLAINT OR AN APPEAL

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.

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.

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 Member Services 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 Investigation or Experimental, please do the following:

a. Call the Member Services Department within 120 days of receiving the adverse determination and let the representative know that You would like to appeal the decision. The Member Services 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 Member Services 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. Member Service is available to You to guide You through this process.

Dental Coverage Appeals

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

BCBSHP Blue Cross and Blue Shield
P. O. Box 1122
Minneapolis, MN 55440-1122

Blue View Vision Coverage Appeals

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

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

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber Eligibility

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

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2. Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic Plan;
3. Be a United States citizen or national; or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. Be a resident of the state of Georgia and meet the following applicable residency standards:

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution;
- Be capable of indicating intent;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange.

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution;
- Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security;
- Not be emancipated;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange.

6. Agree to pay for the cost of Premium that BCBSHP requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B and/or D;
10. Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1. resides, intends to reside (including without a fixed address); or
2. has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard.

Dependent Eligibility

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange 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.
    a. 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.
    b. 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.
    c. 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 or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26.
4. Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

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 Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any Dependent. Your failure to provide this information could result in termination of a Dependent'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

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost-Sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move, provided he or she had Minimum Essential Coverage in effect for one or more days of the 60 days prior to the move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. To continue coverage beyond the first 31 days, please contact the Exchange within 60 days of the date of birth to add the child to the Subscriber's Contract and you must pay BCBSHP timely for any additional Premium due.

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. Please contact the Exchange within 60 days of the placement for adoption or date of adoption to add the child to the Subscriber's Contract and you must pay BCBSHP timely for any additional Premium due.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange

within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Court Ordered Health Coverage

If you are required by a 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, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange, 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 Benefit Period for a Qualified Individual who has made a QHP selection during the annual open enrollment period. The applicant's Effective Date is determined by the Exchange based on the receipt of the completed enrollment form. Benefits will not be provided until the applicable Premium is paid to BCHSHP.

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 unless the Subscriber timely requests a different Effective Date. Advance payments of the premium tax credit and Cost-Sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month;
2. In the case of marriage, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within 60 days of the event; and
3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective based on when a complete application is received, which must be within 60 days of the qualifying event.

Effective dates for special enrollment due to loss of Minimum Essential Coverage include 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;
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.

Effective dates for special enrollment due to loss of Minimum Essential Coverage do not include 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.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under: this Contract. The Exchange 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 the Exchange 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 Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. 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 Exchange applications or other forms or statements the Exchange 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 Exchange 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 the Member may result in termination or rescission of coverage.

WHEN MEMBERSHIP ENDS (TERMINATION)

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 or her coverage with appropriate notice to the Exchange;
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, moves outside the Service Area, etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date);
3. The Member fails to pay his or her Premium, and the grace period has been exhausted;
4. Rescission of the Member's coverage;
5. The QHP terminates or is decertified;
6. The Member changes to another QHP; or
7. The QHP issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"**Grace Period**" refers to either:

1. The 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2. Any other applicable grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
   a) The termination date specified by the Member, if reasonable notice is provided;
   b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
   c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4. In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.

5. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium is paid, consistent with existing State laws regarding grace periods.
6. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7. The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

"Reasonable notice" is defined as fourteen days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. 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 as a Qualified Individual continues to be met.
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract.
3. This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP issuer 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 the 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 covered 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.

This Contract may also be terminated 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 this Contract. Termination will be 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.

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 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. Nonrenewal will not affect an existing claim.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required premium by the end of the grace period, the Contract, is terminated. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's premium in a Benefit Year We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to BCBSHP's right to terminate the Contract, as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. 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 Us 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 Us for the Premium payment due including for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the grace period.

After Termination

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

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

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.

Administrative Fee

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.

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.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to You. For example, sometimes We may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, We may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, We may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to Us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to Us under these programs.

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 Member Services 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 Member Services representative will have forms available that can help guide You to other Blue Cross Blue Shield plans that may be available to You.

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.

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.

Coordination with Medicare

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

Except when federal law requires the Plan to be the primary payor, the benefits under this Plan for members age 65 and older, or members otherwise eligible for Medicare, do not duplicate any benefit for which members are entitled under Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to members shall be reimbursed by or on behalf of the members to the Plan, to the extent the Plan has made payment for such services. For the purpose of the calculation of benefits, if the Member has not enrolled in the Medicare Part B, We will calculate benefits as if they had enrolled.

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.

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.

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 Member Services 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).

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.

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.

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.

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.

Medical Policy and Technology Assessment

BCBSHP 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 / Investigational status or Medical Necessity of new technology. Guidance and external validation of

BCBSHP 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.

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.

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.

Program Incentives

We may offer incentives from time to time, at Our discretion, in order to introduce You to covered programs and services available under this Contract. The purpose of these incentives include, but is not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, encouraging You to update member-related information and encouraging You to enroll automatically to pay Premiums electronically. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or member cost shares. Acceptance of these incentives is voluntary as long as BCBSHP offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.

Questions About Coverage or Claims

If You have questions about Your coverage, contact the BCBSHP Member Services 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 Member Services Department.

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.

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.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility of compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We may not give you notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

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.

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.

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.

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.

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.

Value-Added 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.

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.)

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, you have rights and responsibilities when receiving 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 the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - our company and services;
    - our network of health care providers;
    - your rights and responsibilities;
    - the rules of your health plan;
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health plan and any care you receive;
    - any covered service or benefit decision that your health 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 may 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 an In-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 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 health 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 insurance benefits you have along with your coverage with us.
- Inform Member Services 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 and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

We want to provide high quality benefits and Member Services to our members. Benefits and coverage for services given under the plan are overseen by your Contract and not by this Member Rights and Responsibilities statement.

DEFINITIONS

The following terms, defined in this section, are capitalized throughout the contract so they are easy to identify.

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.

Advance Payments of the Premium Tax Credit (APTC)

The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian

The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

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.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

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.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful difference from the reference product.

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.

Clinical Trial

An organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer of disabling or life-threatening chronic disease in human beings.

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 "When Membership Changes (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 is 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 Benefits." The Deductible may be separate from the annual Deductibles for medical benefits and may or may not accumulate towards satisfying the medical 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 "What is Covered" section for more information.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with Us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

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 of 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.

Emergency Medical Condition (Emergency)

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

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

Emergency Services (Emergency Care)

With respect to an Emergency Medical Condition:

1) A medical or behavioral health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "**stabilize**" means, with respect to an Emergency Medical Condition:

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

Experimental or Investigational

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

Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);

Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;

The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health

Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or

It meets the Technology Assessment Criteria as determined by BCBSHP as outlined in the "Definitions" section of this Contract.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Contract. The Facility must be licensed, accredited, registered or approved by the Joint Commission and The Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by us.

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.

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.

Habilitative Services

Health care services that help a person 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.

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

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

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.

Intensive Outpatient Program

Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to

meeting the biosimilarity standard, is expected to produce the same clinical result as the reference product in any given patient.

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 Member Services at the number on the back of Your Identification Card or check Our website at www.bcbsga.com for more details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90 day supply of Maintenance Medication.

Maximum Allowed Amount

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

The term Minimum Essential Coverage means any of the following: 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 benefits risk pool, or as the Secretary of HHS recognizes.

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-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 You receive the services for which You are seeking. Benefit payments and other provisions of this Contract are limited when a Member uses the services of Non-Network Providers.

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 an HMO Contract 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.

Partial Hospitalization Program

Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

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 Member Services 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 BCBSHP 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.

Plan Year

The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Precertification

Please see the section “Requesting Approval for Benefits” for details.

Predetermination

Please see the section “Requesting Approval for Benefits” for details.

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.

Qualified Health Plan or QHP

The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer

The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Rehabilitative Services

Health care services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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.

Residential Treatment Center/Facility:

A Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability.
2. A staff with one or more Doctors available at all times.
3. Residential treatment takes place in a structured facility-based setting.

4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
6. Is fully accredited by TJC, CARF, NIAHO or COA

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

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

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

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.

State

The term State means each of the 50 States and the District of Columbia.

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.

Tax Dependent

The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer

The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

1) To file an income tax return for the Benefit Year
2) If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
3) That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
4) That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

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.

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

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

We, Us, Our

Is Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP).

You and Your

The Member, Subscriber and each covered Dependent.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version: You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ ɓédé dyí-ɓèdèìn-dèɔ̀ ɓé m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé dé m̀ bídí-wùdùǔn ɓó pídyi. Đá méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̂ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိပိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka
Yin nŋ yic ba ye lëk në yök ku bë yi kuny në thöŋ yin jäm ke cin wëu töu kë piiny. Cl rän töŋ dë kc kë lui në nämba dën t në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសម្គាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áajį' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áajį' hodíílnih. (TTY/TDD: 711)

Nepali
तपाईले यो जानकारी तथा सहयोग आफ्नो भाषामा नःशुल्क प्राप्त गर्ने तपाईको अधकिार हो। सहायताको लागि तपाईको ID कार्डमा दइिएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Avei dreptul să obinei aceste informaii i asistenă în limba dvs. în mod gratuit. Pentru asistenă, apelai numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)۔

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì èrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.