

Health Reimbursement Arrangement (HRA) Plan Summary Plan Description (SPD)



HRA OPTIONS: GOLD, SILVER and BRONZE
Administered By



Effective Date: January 1, 2015

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

If you need assistance with Spanish translation to understand this SPD, you may request it at no additional cost by calling Customer Service at the number on the back of your Member Identification Card (ID card).

INTRODUCTION

This Summary Plan Description (“SPD”) gives you a description of your Benefits while you are enrolled under the State Health Benefit Plan (the “Plan”). The Department of Community Health (DCH) reserves the right to act as sole interpreter of all the terms and conditions of the Plan, except where expressly delegated to the claim administrators. You should read this SPD carefully and keep it handy for reference. A thorough understanding of your coverage will allow you to maximize your Benefits. If you have any questions about the Benefits shown in this SPD, please call the Member Service number on the back of your Member ID Card.

The purpose of this Health Reimbursement Arrangement (“HRA”) option is to pay most of the costs of Medically Necessary medical care, treatment of illness, and accidental injury for Covered Services after a Deductible has been satisfied.

The Plan Benefits described in this SPD are for eligible Health Plan Members only. Throughout this SPD, you will also see references to “we”, “us”, “our”, “you” and “your”. The words “we”, “us” and “our” mean the Department of Community Health, SHBP Division. The words “you” and “your” mean the Covered Person and each covered Dependent. Covered Services are subject to the limitations, exclusions, Deductible and Co-insurance rules given in this SPD. Any group plan or certificate which you may have received before will be replaced by this SPD.

Note: Please refer to the “2015 Eligibility & Enrollment Provisions Booklet” that contains the Plan’s eligibility requirements, posted separately as part of the SPD, at www.dch.georgia.gov/shbp-summary-plan-descriptions.

Many words used in this SPD 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.

If you have any questions about your Plan, please be sure to call the Member Services number listed on the back of your Member ID Card. Also, be sure to go to the Medical Claims Administrator’s website, www.bcbsga.com/shbp for details on how to find a Provider, get answers to questions, and access valuable health tips. For more information about your Pharmacy Benefits see the “Outpatient Prescription Drug Rider” Section of this SPD or go to your Pharmacy Claims Administrator’s website, Express-Scripts.com/GeorgiaSHBP. For more information about your Wellness Benefits, see the “Well-Being Incentive Programs” in the Healthways Section of this SPD or go to the Wellness Administrator’s website, www.BeWellSHBP.com. If you have any enrollment or eligibility questions, call the SHBP Member Services at 800-610-1863 or visit www.mySHBPga.adp.com.

The Benefits described in this SPD or any rider or amendments attached hereto are funded by the Plan Sponsor who is responsible for a portion of their payment. Blue Cross and Blue Shield of Georgia (BCBSGa) provides administrative medical claims payment services only, and Express Scripts only provides administrative pharmacy claims payment services. Healthways, Inc. is the Well-Being program administrator.

How to Get Language Assistance

The Plan is committed to communicating with Members about the Plan. Simply call the Member Services on the back of your Member ID Card, and a representative will be able to help you. To get a copy of the Benefits translated, please contact Member Services. TTY/TDD services also are available.

STATE HEALTH BENEFIT PLAN (SHBP) CONTACT / RESOURCES INFORMATION

	Member	Website
<p>Medical Claims Administrator- Blue Cross Blue Shield of Georgia</p> <p>Member Services Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday</p> <p>Fraud Hotline</p>	<p>855-641-4862 (TTY 711)</p> <p>800-831-8998</p>	<p>www.bcbsga.com/shbp</p>
<p>Wellness Program Administrator- Healthways</p> <p>Member Services Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday</p> <p>Healthways Corporate Compliance</p>	<p>888-616-6411</p> <p>866-225-0836</p>	<p>www.BeWellSHBP.com</p>
<p>Pharmacy Claims Administrator- Express Scripts</p> <p>Member Services Hours: 24 hours a day / 7 days a week</p> <p>Fraud Tip Hotline</p>	<p>877-841-5227</p> <p>866-216-7096</p>	<p>Express-Scripts.com/GeorgiaSHBP</p> <p>email: fraudtip@express-scripts.com</p>
<p>SHBP Member Services</p> <p>Hours: 8:30 a.m. – 5:00 p.m. ET Monday – Friday</p>	<p>800-610-1863</p>	<p>www.mySHBPga.adp.com</p>
<p>Additional Information</p>		
<p>Centers for Medicare & Medicaid (CMS)</p> <p>24 hours a day / 7 days a week</p>	<p>800-633-4227 TTY 877-486-2048</p>	<p>www.medicare.gov</p>

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SCHEDULE OF BENEFITS

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles and Co-insurance that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the Medical Claims Administrators' policies, Plan limitations, Plan Benefit Exclusions, terms and conditions of this SPD including any endorsements, amendments, or riders.

To receive the highest level of benefits at the lowest out-of-pocket cost, receive Covered Services from an In-Network Provider. An In-Network Provider during an office visit may need to utilize, order, or refer you to other Providers for additional services. To maximize your Benefits, ask your In-Network provider to utilize or refer you to other In-Network Providers. Examples include, but are not limited to, laboratory (known as reference laboratory services) and radiology. For more information, call the BCBSGa Member Services number on the back of your Member ID card.

Co-insurance is a percentage of the Maximum Allowed Amount, which is the most the Medical Claims Administrator will allow for a Covered Service. When you use an In-Network Provider, you are not responsible for amounts above the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charge for Covered Services (balance billing) in addition to any Co-insurance, Deductibles, and non-covered charges. This amount can be substantial. Deductibles, Co-insurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges. Please read the "Medical Claims Payment" section for more details.

Note: Pharmacy Benefits are administered separately by the Pharmacy Administrator, Express Scripts and are the same in all Plan Options- Gold, Silver, and Bronze HRA Plans. See the table "Prescription Drug Pharmacy Benefits" in this Section & the "Outpatient Prescription Drug Rider" Section in this SPD.

Benefit Period	2015 Calendar Year
Dependent Age Limit	To the end of the month in which the child reaches age 26; Please see the separate "2015 Eligibility & Enrollment Provisions Booklet" posted at www.dch.georgia.gov/shbp-summary-plan-descriptions for further details.

SHBP Base HRA Credits Contributions to Your HRA	Gold HRA Plan	Silver HRA Plan	Bronze HRA Plan
You	400	200	100
You + Spouse	600	300	150
You + Children	600	300	150
You + Family	800	400	200

NOTE: Health Reimbursement Arrangement (HRA) well-being incentive credits will reduce your Deductible and Co-insurance cost shares. Prescription costs do apply to your HRA well-being incentive credits, if any are available.

If you do not use all of the HRA well-being incentive credits in your HRA, it rolls over from year to year, as long as you remain enrolled in a SHBP HRA plan. See "Well-Being Incentive Programs" in the Healthways Section of the SPD on how to earn more HRA well-being incentive credits.

Deductible	Gold HRA Plan		Silver HRA Plan		Bronze HRA Plan	
SHBP Coverage Tier	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
You	\$1,500	\$3,000	\$2,000	\$4,000	\$2,500	\$5,000
You+ Spouse	\$2,250	\$4,500	\$3,000	\$6,000	\$3,750	\$7,500
You+ Children	\$2,250	\$4,500	\$3,000	\$6,000	\$3,750	\$7,500
You +Family	\$3,000	\$6,000	\$4,000	\$8,000	\$5,000	\$10,000

The Deductible applies to all Covered Services unless otherwise indicated.

No benefits are payable until the Calendar Year Deductible is satisfied, unless otherwise indicated. HRA credits will reduce your Deductible.

The Deductible amount any one person can satisfy cannot be more than the You deductible.

The In-Network and Out-of-Network Deductibles are separate and cannot be combined. Covered Services by Out-of-Network Providers are processed as Out-of-Network and subject to the Member's Out-of-Network Deductible and Co-insurance.

Prescription costs do not apply to the Deductible.

Note: The Family Deductible is an aggregate Deductible. This means any combination of amounts paid by family Members toward Covered Services can be used to satisfy the Family Deductible.

Co-insurance	Gold HRA Plan In-Network	Silver HRA Plan In-Network	Bronze HRA Plan In-Network	Out-of-Network (All Plans)
Plan Pays (unless otherwise noted)	85%	80%	75%	60%
Member Pays (unless otherwise noted)	15%	20%	25%	40%

Your Co-insurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Co-insurance plus the difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charge (balance billing) for Covered Services.

Your Co-insurance for Out-of-Network Providers will be based on the Maximum Allowed Amount for Covered Services. You may have to pay this Co-insurance amount plus the difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charge (balance billing) for Covered Services. Covered Services by Out-of-Network Providers are processed as Out-of-Network and subject to the Member's Out-of-Network Co-insurance.

Note: Pharmacy benefits are administered separately by the Pharmacy Administrator and are the same in all Plan Options- Gold, Silver, and Bronze HRA Plans.

Out-of-Pocket Maximum	Gold HRA Plan		Silver HRA Plan		Bronze HRA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
SHBP Coverage Tier						
You	\$4,000	\$8,000	\$5,000	\$10,000	\$6,000	\$12,000
You + Spouse	\$6,000	\$12,000	\$7,500	\$15,000	\$9,000	\$18,000
You + Children	\$6,000	\$12,000	\$7,500	\$15,000	\$9,000	\$18,000
You + Family	\$8,000	\$16,000	\$10,000	\$20,000	\$12,000	\$24,000

The Out-of-Pocket Maximum limit includes all Deductibles and Co-insurance you pay during a Benefit Period unless otherwise indicated.

The Out-of-Pocket Maximum for an individual is equal to and will not be more than the You Out-of-Pocket Maximum.

The Out-of-Pocket Maximum does not include amounts you pay for the following benefits:

- Charges over the Maximum Allowed Amount
- Penalties for not getting required Prior Authorization / Precertification of services
- Amounts you pay for non-Covered Services
- HRA credits will reduce the Out-of-Pocket Maximum

The In-Network and Out-of-Network Out-of-Pocket Maximums are separate and do not apply toward each other.

Pro-ration does not apply to the Out-of-Pocket Maximum.

Prescription costs do apply to the Out-of-Pocket Maximum.

Once the Out-of-Pocket Maximum is satisfied, you will not have to pay any additional Deductibles or Co-insurance for medical Covered Services for the rest of the Benefit Period, except for the services listed above.

Important Notice about Your Cost Shares

In certain cases, if a Provider is paid amounts that are your responsibility, such as Deductibles and Co-insurance, such amounts may be collected directly from you. You agree that the Medical Claims Administrator, on behalf of the Plan, has the right to collect such amounts from you.

Gold, Silver, & Bronze HRA Plans	
Prescription Drug Pharmacy Benefits Co-insurance you must pay	
31-day supply for a participating Retail Network Pharmacy	
Tier 1 Co-insurance Generic	15% (\$20 min/ \$50 max) for up to 31-day supply
Tier 2 Co-insurance (Preferred) Brand	25% (\$50 min/ \$80 max) for up to 31-day supply
Tier 3 Co-insurance (Non-Preferred) Brand	25% (\$80 min/ \$125 max) for up to 31-day supply
90-day Supply for maintenance drugs from mail order OR at participating 90-Day Retail Network Pharmacies	
Tier 1: 2½ x the monthly Co-insurance	15% (\$50 min/ \$125 max) for up to a 90-day supply
Tier 2: 2½ x the monthly Co-insurance	25% (\$125 min/ \$200 max) for up to a 90-day supply
Tier 3: 2½ x the monthly Co-insurance	25% (\$200 min/ \$313 max) for up to a 90-day supply
90-day Supply for maintenance drugs from a Retail Network Pharmacy which is not part of the 90-Day Retail Network Pharmacies	
Tier 1: 3 x the monthly Co-insurance	15% (\$60 min/ \$150 max) for up to a 90-day supply
Tier 2: 3 x the monthly Co-insurance	25% (\$150 min/ \$240 max) for up to a 90-day supply
Tier 3: 3 x the monthly Co-insurance	25% (\$240 min/ \$375 max) for up to a 90-day supply
<p>Prescription drug pharmacy benefits are administered separately by the Pharmacy Administrator, Express Scripts and are the same in all three Plan options- Gold, Silver, and Bronze HRA Plans.</p> <p>Co-insurance for a Prescription Drug Product at Network Pharmacy is a percentage of the allowed amount. Your Co-insurance is based on the applicable drug tier. Co-insurance will not be overridden or changed on an individual basis.</p> <p>Please see the “Outpatient Prescription Drug Rider” in this SPD.</p> <p>If a generic product is available and you choose to use the branded product instead, then you will pay the applicable generic co-insurance plus the cost difference between the generic product and its brand product. This differential will not apply to your Out-of-Pocket Maximum.</p> <p>Note: Prescription costs do not apply to the Deductible but do apply to the Member’s Out-of-Pocket Maximum.</p>	

Cost shares you must pay for Covered Services
Please refer to the Section “What’s Covered” for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Allergy Services				
<ul style="list-style-type: none"> Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) (Testing & Treatment) 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Ambulance Services (Air, Water and Ground)	15% Co-insurance per trip after Deductible	20% Co-insurance per trip after Deductible	25% Co-insurance per trip after Deductible	Same as In-Network
Out-of-Network Providers may also bill you for any charges that exceed the Plan’s Maximum Allowed Amount.				
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see “Getting Approval for Benefits” for details.				
All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see “Getting Approval for Benefits” for details.				
Autism Spectrum Disorder (ASD) Applied Behavior Analysis (ABA)				
	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
Important Note: Prior Authorization is required and is limited to medically necessary ABA for the treatment of ASD to a maximum benefit of \$35,000 per year per approved member (through age 10).				
Cardiac Rehabilitation				
<ul style="list-style-type: none"> Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> Outpatient Facility Services 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Cardiac Rehabilitation Benefit Maximum 	40 visits per Benefit Period In- and Out-of-Network visits combined			
Note: The limit for cardiac rehabilitation will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.				

Cost shares you must pay for Covered Services
Please refer to the Section "What's Covered" for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Chemotherapy / Non-Preventive Infusion & Injection				
<ul style="list-style-type: none"> Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> Outpatient Facility Services 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Chiropractic Services / Manipulation Therapy				
<ul style="list-style-type: none"> Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> Outpatient Facility Services <ul style="list-style-type: none"> Chiropractic Services / Manipulation Therapy Benefit Maximum 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
		20 visits per Benefit Period In- and Out-of-Network visits combined		
Diagnostic Services				
Advanced Diagnostic Imaging (including MRIs, CAT scans) Diagnostic Labs (non-preventive) (i.e., reference labs) Diagnostic X-ray (non-preventive)				
<ul style="list-style-type: none"> Inpatient Facility Services 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> Outpatient Facility Services 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Dialysis / Hemodialysis				
<ul style="list-style-type: none"> Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> Outpatient Facility Services 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible

Cost shares you must pay for Covered Services
Please refer to the Section "What's Covered" for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	15% Co-insurance after Deductible	20% Co-insurance After Deductible	25% Co-insurance After Deductible	40% Co-insurance After Deductible
Emergency Services				
Emergency Room				
• Emergency Room Facility Charge	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Emergency Room Doctor Charge	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Non-emergency use of Emergency Room Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Note: Out-of-Network Providers may bill you for charges over the Plan's Maximum Allowed Amount.				
Foot Orthotics Covered for a diagnosis of diabetes				
	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ Foot Orthotics Benefit Maximum	1 pair every 3 years			
Hearing Aids				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) Non-Routine Hearing Exams, Tests & Fittings	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Hearing Aids	0% Co-insurance No Deductible	0% Co-insurance No Deductible	0% Co-insurance No Deductible	Same as In-Network
○ Hearing Aid Benefit Maximum	Limited to: \$1,500 every 5 years for adults and \$3,000 every 5 years for children (0 up to 19)			

Cost shares you must pay for Covered Services
Please refer to the Section “What’s Covered” for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Home Care				
<ul style="list-style-type: none"> Home Care Visits Home Dialysis Home Infusion Therapy Other Home Care Services / Supplies 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Hospice Care				
<ul style="list-style-type: none"> Home Care Respite Hospital Stays 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Note: Out-of-Network Providers may also bill you for any charges over the Plan’s Maximum Allowed Amount.				
Human Organ and Tissue Transplant (Bone Marrow /Stem Cell) Services				
Precertification and Prior Approval required (except for cornea and kidney)				
<ul style="list-style-type: none"> Transportation and Lodging 	15% Co-insurance no Deductible	20% Co-insurance no Deductible	25% Co-insurance no Deductible	Not Covered unless *BDCT Facility used.
<ul style="list-style-type: none"> Transportation and Lodging Limit 	Covered, as approved by BCBSGa, up to \$10,000 per transplant Out-of-Network Not Covered Lodging \$50 per day for double occupancy			
<ul style="list-style-type: none"> Donor Search 	15% Co-insurance no Deductible	20% Co-insurance no Deductible	25% Co-insurance no Deductible	Not Covered unless *BDCT Facility used.
<ul style="list-style-type: none"> Donor Search Limit Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure 	Covered, as approved by us, up to \$30,000 Lifetime Maximum Out-of-Network Not Covered			
Note: *The Medical Claims Administrator has Centers of Excellence (COE) Network selected to provide specific services to Members. Members must use a Blue Distinction Center for Transplants (BDCT) or one of the Center of Medical Excellence (CME) Transplant Network facilities to receive benefits for transplant services. Contact BCBSGa Member Services at the number on the back of your Member ID card for details.				
Infertility				
Limited to diagnostic services. Treatment of infertility is not covered.	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible

Cost shares you must pay for Covered Services
Please refer to the Section “What’s Covered” for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Inpatient Facility Services				
Facility Room & Board Charge:				
• Hospital / Acute Care Facility	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Doctor Service Charges:				
• General Medical Care / Evaluation and Management (E&M)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Surgery	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Note: For Emergency admissions, you (or your authorized representative) or Doctor must inform the Medical Claims Administrator within 48 hours of the admission.				

Maternity and Reproductive Health Services				
• Maternity Services Note: Deductible applies to mother and well-newborn charges.	15%Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40%Co-insurance after Deductible
• Prenatal Office Visit Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Physician Office Visits Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15%Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40%Co-insurance after Deductible
• Inpatient Services (Delivery)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Inpatient Facility Services Note: Deductible applies to mother and well-newborn charges.	15%Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40%Co-insurance after Deductible
• Inpatient Doctor Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Note: Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged home, Covered Services for the newborn will be treated as a separate admission requiring precertification with Deductible, Co-insurance, & Out-of-Pocket applied. You must also add the dependent to the Plan. Please refer to the “2015 Eligibility & Enrollment Provisions Booklet” that contains the Plan’s eligibility requirements, posted separately as part of the SPD, at www.dch.georgia.gov/shbp-summary-plan-descriptions .				

Cost shares you must pay for Covered Services
Please refer to the Section “What’s Covered” for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Mental Health and Substance Abuse Services				
• Inpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Inpatient Doctor Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Doctor Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Partial Hospitalization Program / Intensive Outpatient Program Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15%Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40%Co-insurance after Deductible
Nutritional Counseling & Childhood Obesity				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	0% Co-insurance No Deductible	0% Co-insurance No Deductible	0% Co-insurance No Deductible	Same as In-Network
○ Nutritional Counseling – Benefit Maximum	Nutritional Counseling Benefit Maximum: 3 visits per medical condition per lifetime by a Registered Dietitian (except for childhood obesity listed below)			
• Childhood Obesity	0% Co-insurance No Deductible	0% Co-insurance No Deductible	0% Co-insurance No Deductible	Same as In-Network
○ Benefit Maximum	Nutritional Counseling Children (Childhood Obesity) Benefit Maximum: For ages 3-18 with a 4 visit limitation per Calendar Year for Physicians and 4 visit limitation per Calendar Year for Registered Dietitians who qualify as determined by their Physician.			
Note: Under the medical benefit for these non-preventive services, Out-of-Network covered at the In-Network level of benefits at the billed amount.				

Cost shares you must pay for Covered Services
Please refer to the Section “What’s Covered” for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Occupational Therapy				
<ul style="list-style-type: none"> • Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) • Outpatient Facility Services <ul style="list-style-type: none"> ○ Occupational Therapy Benefit Maximum 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
		40 visits per Benefit Period In- and Out-of-Network visits combined		
Note: The limit for occupational therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.				
Office Visits and Physician Services				
<ul style="list-style-type: none"> • Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) • Retail Health Clinic Visit • Office Surgery • Prescription Drugs Administered in the Office 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Outpatient Facility Services				
<ul style="list-style-type: none"> • Facility Surgery Charge • Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies) • Doctor Surgery Charges • Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant) • Other Facility Charges (for procedure rooms or other ancillary services) • Prescription Drugs Administered in an Outpatient Facility 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible

Cost shares you must pay for Covered Services
Please refer to the Section “What’s Covered” for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Physical Therapy				
<ul style="list-style-type: none"> • Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) • Outpatient Facility Services <ul style="list-style-type: none"> ○ Physical Therapy Benefit Maximum 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
			40 visits per Benefit Period In- and Out-of-Network visits combined	
Note: The limit for physical therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.				
Preventive Care				
	0% No Deductible or Co-insurance	0% No Deductible or Co-insurance	0% No Deductible or Co-insurance	Not Covered
Note: Preventive care services must meet the requirements of federal and state law. Certain Preventive care services are Covered Services with no Deductible or Co-insurance when you utilize an In-Network Provider and the service is properly coded as preventive care. That means the Plan covers 100% of the Maximum Allowed Amount with no Member cost share for these certain Covered Services.				
Radiation Therapy / Chemotherapy / Non-Preventive Infusion & Injection				
<ul style="list-style-type: none"> • Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) • Outpatient Facility Services 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Respiratory and Pulmonary Therapy				
<ul style="list-style-type: none"> • Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) • Outpatient Facility Services ○ Respiratory Therapy Benefit Maximum 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
			40 visits per Benefit Period In- and Out-of-Network visits combined	

Cost shares you must pay for Covered Services
Please refer to the Section “What’s Covered” for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Skilled Nursing Facility				
<ul style="list-style-type: none"> • Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Not Covered
<ul style="list-style-type: none"> ○ Skilled Nursing Benefit Maximum 	120 days per Benefit Period			
Speech Therapy				
<ul style="list-style-type: none"> • Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> • Outpatient Facility Services 	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
<ul style="list-style-type: none"> ○ Speech Therapy Benefit Maximum 	40 visits per Benefit Period In- and Out-of-Network visits combined			
Note: The limit for speech therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.				
Surgery				
	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Temporomandibular and Craniomandibular Joint Treatment				
	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Urgent Care Services				
	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible

Cost shares you must pay for Covered Services
Please refer to the Section "What's Covered" for additional detail

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Vision Exam				
For routine services	0% No Deductible or Co-insurance	0% No Deductible or Co-insurance	0% No Deductible or Co-insurance	Not Covered
Vision Exam Benefit Maximum	1 Exam every 24 months			
Note: Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit when provided by an In-Network Provider and properly coded as Preventive Care.				
Vision Services				
For non-routine services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Note: Eye refraction testing is covered. Vision hardware, glasses or contact lenses are only covered following cataract surgery.				
Wigs				
	0% Co-insurance after Deductible	0% Co-insurance after Deductible	0% Co-insurance after Deductible	Same as In-Network
o Wigs Benefit Maximum	\$750 per Lifetime, subject to Medical Necessity			
Note: Wigs are excluded regardless of the reason for the hair loss, with the exception of hair loss relating to cancer/chemotherapy treatment.				

HOW THE SHBP HRA PLAN WORKS FOR YOUR BENEFITS

The SHBP HRA (Health Reimbursement Arrangement) offers you a different approach for managing your health care costs. SHBP funds HRA credits to your HRA to provide first dollar coverage for those Covered Services requiring a Deductible/Co-insurance and pharmacy Co-insurance. The HRA well-being incentive credits are used to reduce your out-of-pocket amount you must pay. After satisfying your Deductible, you will pay your Co-insurance amount for Covered Services until you reach your Out-of-Pocket Maximum. If you do not use all your HRA credits, the HRA credits roll over from year to year, as long as you remain enrolled in a SHBP HRA plan option.

HRA consists of three components:

1. HRA is funded by the SHBP and maintained by BCBSGa. SHBP contributes base HRA credits to your HRA. These credits are used to help pay for medical Covered Services and pharmacy Co-insurance as available in your HRA.

SHBP Coverage Tier	Gold Base HRA Credits	Gold HRA after completion of all 2015 incentive actions (base HRA credits + earned well-being credits)	Silver Base HRA Credits	Silver HRA after completion of all 2015 incentive actions (base HRA credits + earned well-being credits)	Bronze Base HRA Credits	Bronze HRA after completion of all 2015 incentive actions (base HRA credits + earned well-being credits)
You	400	880	200	680	100	580
You + Child(ren)	600	1,080	300	780	150	630
You + Spouse	600	1,560	300	1,260	150	1,110
You + Family	800	1,760	400	1,360	200	1,160

Note: SHBP Members will have access to a variety of Healthways' tools, activities and services to earn additional well-being incentive credits. To learn more, please see the Healthways' Section of this SPD, visit www.BeWellSHBP.com, or call Healthways' Member Services on the back of your Member ID Card.

2. Annual Deductibles and Co-insurance. You are responsible for paying your annual Deductible before the Plan begins to pay a percentage for Covered Services. The credits in your HRA are used to help meet your Deductible. If you've been enrolled in the plan for more than one year, you may have enough saved to pay for your entire Deductible. After you meet your Benefit year Deductible, you pay a percentage of the Maximum Allowed Amount for Covered Services called Co-insurance. If you still have HRA credits in your HRA after you have met your annual Deductible, you can use those HRA credits to pay your share of Co-insurance. Once you reach your annual Out-of-Pocket Maximum, the Plan pays 100 percent for any Covered Services incurred during the remaining Benefit year.

Note: The Deductibles and Out-of-Pocket Maximums are separate for In-Network and Out-of-Network Covered Services.

3. Earn additional well-being credits. Members and/or covered spouses can earn additional well-being credits for their HRA. Healthways administers the 2015 action-based incentives. To earn these

well-being credits, complete the activities between January 15 and December 15, 2015. Please see the Healthways' Section of this SPD.

4. Additional Health Information online tools and customer service support. Members have access to BCBSGa and Express Scripts online tools and Member Services to have a better understanding of their medical and pharmacy costs.

Regarding Your SHBP Health Reimbursement Arrangement (HRA):

- The HRA credits placed in your HRA will depend on the option elected by the Member. For example if enrolled in the Bronze Option at the beginning of the Benefit year in the single tier, SHBP will fund 100 credits in this account.
- If you are a new hire or newly enrolled in the HRA Option within the plan year, the HRA credits in your HRA will be pro-rated based on the number of months remaining in the Benefit year. The Deductible and Out-of-Pocket Maximum are not pro-rated.
- If you experience a qualifying event and increase your coverage tier, your new HRA credits will be pro-rated based on the number of months remaining in the Benefit year.
- If you experience a qualifying event and decrease your coverage tier, the amount placed in your HRA for that plan year will not change.
- If you or an enrolled Dependent(s) experience a qualifying event which results in coverage under a new contract, the entire Deductible and Out-of-Pocket Maximum under the new contract will have to be met. All HRA balances, Deductibles and Out-of-Pocket Maximums will remain with the prior contract. Pro-rated HRA credits will be deposited into the new contract based on the elected coverage tier and months remaining in the current plan year. Deductibles and Out-of-Pocket Maximums are not pro-rated.
- If your employment terminates for any reason, the credits in your HRA will revert back to the SHBP, unless you elect COBRA coverage and remain under the same contract. See the "Eligibility & Enrollment Provisions Booklet" posted www.dch.georgia.gov/shbp-summary-plan-descriptions in the separate SPD for COBRA coverage details. The HRA credits will remain available to assist you in paying your Out-of-Pocket costs while COBRA coverage is in effect.

Covered Services received from an In-Network Provider

When you receive Covered Services requiring Co-insurance from an In-Network Provider, the HRA credits in your HRA may be used to help you meet your Benefit year Deductible. Once the Benefit year Deductible is met, you are responsible for your cost share for those Covered Services requiring Co-insurance. HRA credits remaining in your HRA may be used to assist you in paying this difference.

Filing a Claim for Out-of-Network Benefits

If you have HRA credits in your HRA and you receive health services from an Out-of-Network Provider, you are responsible for filing a request for reimbursement. The request for claim reimbursement from your HRA credits may be made for claims incurred while you are considered a Covered Person under your medical plan.

Required Information for Filing an Out-of-Network Claim

When you request reimbursement from your HRA, you must complete the Health Reimbursement Arrangement (HRA) Claim Form and attach the itemized documentation as described on that form. The form is available on www.bcbsga.com/shbp or by calling the BCBSGa Member Service number on your Member ID card.

MEDICAL CLAIMS ADMINISTRATOR



HOW YOUR MEDICAL PLAN WORKS

BCBSGa is the Medical Claims Administrator for SHBP. Your Plan is an Open Access (OA) Point of Service (POS) Preferred Provider Organization (PPO) plan, otherwise known as the SHBP network. Providers who are not contracted with BCBSGa are considered Out-of-Network for Covered Services. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Deductible and Co-insurance and you will not be responsible for billed charges above the Maximum Allowed Amount.

If you use an Out-of-Network Provider, you may have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charge for Covered Services (balance billing) in addition to the Out-of-Network Deductible and Co-insurance. For Out-of-Network Providers, the Plan does not accept assignment of benefits. You will receive a payment of benefits and it will be your responsibility to pay that to the provider.

In-Network Services and Providers

In-Network Providers include Primary Care Physicians/Providers (PCP), Specialists (Specialty Care Physicians/Providers (SCP), other professional Providers, Hospitals, and other Medical Facilities who contract with the Medical Claims Administrator to provide health care services.

Members have access to primary and specialty care directly from any In-Network Provider. A Primary Care Physician/Provider (PCP) Referral is not needed.

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, Benefits will be denied for care that is not a Covered Service. The Medical Claims Administrator has final authority to decide the Medical Necessity of the service.

When you call or go to see a Doctor, tell them you are a BCBSGa State Health Benefit Plan Member. Keep your Member ID Card with you. The Doctor's office will ask you for your group or Member ID number and usually make a copy of your card.

For services from In-Network Providers:

1. You will not be required to file any claims. In-Network Providers will file claims for Covered Services for you (You will still need to pay applicable Deductibles, and Co-insurance). You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have

not followed the terms of this SPD.

2. Precertification will be done by the In-Network Provider. See the Section “Getting Approval for Benefits” further details.

Please refer to the Section on “Medical Claims Payment” for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. Call your Doctor’s office for after hour’s instructions if you need care in the evenings, weekends, or during a holiday, and cannot wait until the office reopens. If you’re not sure where to go for care and your Doctor is not available, you can also call the 24/7 Nurse Line at 866-787-6361. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services and Providers

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are reimbursed at the Out-of-Network level, unless otherwise indicated in this SPD.

For Covered Services from an Out-of-Network Provider:

1. The Out-of-Network Providers can charge you the Out-of-Network Deductible and/or Co-insurance plus any amount above the plan’s Maximum Allowed Amount;
2. You may have higher cost sharing amounts (i.e., Deductibles, and/or Co-insurance);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see “Getting Approval for Benefits” for more details.)
7. For Out-of-Network Providers, the Plan does not accept assignment of benefits. You will receive a payment of Benefits and it will be your responsibility to pay that to the Out-of-Network Provider directly.

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:

- View the directory of In-Network Providers at www.bcbsga.com/shbp, which lists the Doctors, Providers, and Facilities that participate in BCBSGa’s Open Access Point of Service (POS) Preferred Provider Organization (PPO) plan.
- Call BCBSGa Member Services to ask for a list of Doctors and other Providers that participate in the network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Note: Not all In-Network Providers offer/refer all services In-Network. Ask your provider if they are using In-Network Providers when delivering their services to you or referring you for services such as laboratories (known as reference laboratory services) or radiology. A Reference Laboratory is a freestanding lab outside of the Physician’s office such as LabCorp.

If you need help choosing a Doctor, call the BCBSGa Member Service number on the back of your Member ID Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with the Medical Claims Administrator to help with your needs.

Your Cost-Shares

See the “Definitions” Section for a better understanding of each type of cost share.

The BlueCard Program

The Medical Claims Administrator BCBSGa, licensed in Georgia, participates in a program called “BlueCard”. This program gives you access to Providers participating in the Blue Cross and Blue Shield Association BlueCard network across the country. The BlueCard network allows Covered Services at the In-Network cost-share when you are traveling outside of the State of Georgia and need health care, as long as you use a BlueCard Provider. All you have to do is show your Member ID Card to a participating Blue Cross & Blue Shield Provider. The Provider will send your claims to the Medical Claims Administrator. To find the nearest contracted Provider, visit the BlueCard Doctor and Hospital Finder website at www.BCBS.com or call the number on the back of your Member ID Card.

Note: If you are out-of-state and an emergency or urgent situation arises, you should get care right away.

Identification Card (ID card)

The Medical Claims Administrator will give each Member enrolled in the Plan an Identification Card. When you go to any Hospital or medical Facility for care, you must show your Member ID Card. Only covered Members have the right to receive services under this Plan. If anyone gets services or Benefits they are not entitled to under the terms of this SPD, he/she must pay for the actual cost of the all services.

GETTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Prior Authorization, Precertification, Predetermination and Post Service Clinical Claims Reviews to determine when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting (or the place of service) in which these are performed. Covered Services must be Medically Necessary for Benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

The Medical Claims Administrator will use clinical coverage guidelines, such as medical policy, preventive care clinical coverage guidelines, and other applicable policies to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Medical Claims Administrator reserves the right to review and update these clinical coverage guidelines.

If you have any questions about the information in this Section, you may call BCBSGa Member Services number on the back of your Member ID Card.

Types of Requests

- **Prior Authorization** – Network Providers must obtain Prior Authorization in order for you to get Benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy and clinical guidelines. The Medical Claims Administrator may determine that a service that was first prescribed or requested is not Medically Necessary if you have not tried other treatments which are more cost effective.
- **Precertification** – A required prospective review of a service, treatment, admission or Continued Stay Review for a determination of benefit coverage.
- **Predetermination** – An optional, voluntary prospective or a request for a benefit coverage determination regarding a service or treatment. The predetermination coverage review will include a review to see if there is a related clinical coverage guideline or medical policy, the service meets the definition of Medical Necessity under this Plan, is it Experimental / Investigational as that term is defined in this Plan, or a Benefit Exclusion under the Plan.
- **Post Service Clinical Claims Review** – A retrospective review for a benefit coverage determination: (1) to verify Medical Necessity; (2) to determine if the service rendered is a Covered Benefit; (3) to determine if it is of an Experimental / Investigational nature of a service, treatment or admission that did not need Precertification, and (4) if it did not have a Predetermination review performed. The reviews are done for a service, treatment or admission in which the Medical Claims Administrator has a related clinical coverage guideline policy, and are typically initiated by the Medical Claims Administrator.

The Provider or Facility should contact the BCBSGa to request a Precertification or Predetermination review. The BCBSGa will work directly with the requesting Provider for the Prior Authorization, Precertification, or Predetermination request. However, you may designate an authorized representative (anyone who is 18 years of age or older) to act on your behalf for a specific request.

Who is Responsible for Getting Approval

<p>Services provided by an In-Network Provider, including BlueCard Providers in the service areas of various Anthem Blue Cross and Blue Shield States: CA, CO, CT, IN, KY, ME, MO, H, NV, NY, OH, VNA, WI</p>	<p style="text-align: center;">In-Network Provider</p>
<p>Services provided by any Out-of-Network or Non-Participating Provider.</p>	<ul style="list-style-type: none"> • Member must obtain Precertification. • If Member fails to obtain Precertification, Member may be financially responsible for service and/or setting in whole or in part.

You are entitled to ask for and receive, at no cost, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Member ID Card.

The Medical Claims Administrator may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management), if in the Medical Claims Administrator’s discretion such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may also be selected to take part in a program that exempts the Medical Claims Administrator from certain procedural or medical management processes that would otherwise apply. The Medical Claims Administrator may also exempt your claim from medical review, if certain conditions apply.

Just because the Medical Claims Administrator exempts a process, Provider, or claim from the standards which would apply, does not mean that the Medical Claims Administrator will do so in the future for any other Provider, claim or Member. The Medical Claims Administrator may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by checking your online Provider directory or by contacting BCBSGa Member Services on the back of your Member 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 this Plan’s Members.

Request Categories

- **Urgent:** A request for Precertification or Predetermination, that in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, could

seriously threaten your life or health or your ability to regain maximum function (or subject you to severe pain) that cannot be adequately managed without such care/treatment.

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

Decision and Notice Requirements

The Medical Claims Administrator will review requests for Benefits according to the timeframes (based in general on federal regulations) listed below:

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

If more information is needed to make a decision, the Medical Claims Administrator will tell the requesting Provider (and you / your authorized representative) of the specific information needed to complete the review. If the Medical Claims Administrator does not get the specific information needed or if the information is not complete by the timeframe identified in the written notice, a decision will be made based upon the information received.

The Medical Claims Administrator will give notice of its determination (as required by state and federal law) by either:

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

- **Written:** Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider, and you / your authorized representative

Note: Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For Benefits to be covered, on the date you receive a service:

1. You must be eligible for Benefits;
2. The service or supply must be a Covered Service under your Plan;
3. The service cannot be subject to an Exclusion under your Plan; and
4. You must not have exceeded any applicable limits under your Plan.

Services Requiring Precertification/Prior Approval

Note: To obtain Precertification or Prior Approval, Members must call the BCBSGa Personal Health Coach team at 855-668-6442 for the certain services to be provided by either an In-Network or an Out-of-Network provider. This is a dedicated line to obtain Precertification and Prior Approval. It is your responsibility to notify BCBSGa of certain services and obtain Precertification and Prior Approval. Services that require Prior Authorization/Precertification include:

Inpatient Services

- Acute Inpatient (including transplants)
- Sub-acute inpatient (Skilled Nursing and Long Term Care)
- Inpatient rehabilitation
- Maternity delivery if inpatient stay extends 48 hours following a normal vaginal delivery and 96 hours following caesarean
- Out-of-network or out-of-area non-emergency services

Outpatient and/or other Inpatient Services

- Ankle replacement
- Applied Behavioral Analysis (ABA) Therapy
- Back pain (chronic), percutaneous neurolysis
- Blepharoplasty, blepharoptosis repair, and brow lift
- Bone Growth Stimulator: Electrical or Ultrasound
- Breast procedures including reduction mammoplasty, reconstructive surgery, implants and other breast procedures
- Cardiac resynchronization therapy for heart failure treatment
- Cardiac transcatheter closure of patent foramen ovale and left atrial appendage for stroke prevention
- Cardiac ventricular septal defect transmyocardial/periventricular device closure
- Cardio-reduction, partial left ventriculectomy
- Cardioverter defibrillators, implantable (ICD) and wearable
- Clinical Trials
- Cochlear implants and auditory brainstem implants
- Communication/speech generating devices, augmentative and alternative (ACC)
- Cosmetic and reconstructive services of the head and neck; trunk and groin
- Cosmetic and reconstructive services, skin related
- Dental care due to accident or injury
- Durable Medical Equipment
- Endoscopy, Capsule
- Functional electrical stimulation (FES); threshold electrical stimulation (TES)
- Genetic testing for cancer susceptibility, BRCA Genetic Testing Program
- Hearing aids, bone-anchored and implantable, middle ear
- Heart monitors, real-time remote
- Home Health Care Nutritional/Enteral Therapy
- Home Health Care; Home Infusion

- Home phototherapy for neonatal hyperbilirubinemia
- Hyperbaric oxygen therapy (systemic/topical)
- Hyperhidrosis
- Hysterectomy, Abdominal and vaginal
- Infusion pumps, implantable
- Infusion pumps, insulin, external (portable) continuous
- Intervertebral discs, cervical artificial and lumbar artificial
- Knee Arthroplasty, Total and Bicompartamental
- Mandibular/maxillary (orthognathic) surgery
- Nasal surgery for the treatment of obstructive sleep apnea (OSA) and radiofrequency ablation of nasal turbinates for nasal obstruction with or without OSA
- Obstructive sleep apnea treatment in adults
- Obstructive sleep apnea; oral, pharyngeal and maxillofacial surgical treatment
- Oral Surgery
- Oscillatory devices for airway clearance including high frequency chest compression (Vest™ airway clearance system) and intrapulmonary percussive ventilation (IPV)
- Penile prosthesis implantation
- Powered mobility devices
- Prosthesis, microprocessor controlled lower limb
- Prosthetic devices, myoelectric upper extremity
- Radiofrequency volumetric tissue reduction (RFVTR) of the soft palate, uvula, or tongue base (including Coblation and Somnoplasty)
- Sacral nerve stimulation as treatment of neurogenic bladder secondary to spinal cord injury
- Sacroiliac joint fusion
- Septoplasty
- Shoulder Arthroplasty
- Sinuplasty, balloon
- Sleep disorder testing
- Specialty Medications/Injectable Medications
- Spinal artificial intervertebral discs
- Spinal cord stimulators (SCS), implanted
- Spinal percutaneous and endoscopic procedures (vertebroplasty, kyphoplasty, sacroplasty)
- Spinal stenosis, implanted devices
- Spine and joints other than the knee, manipulation under anesthesia
- Spine surgery lumbar – laminectomy, fusion and artificial intervertebral disc
- Standing frames
- Stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT)
- Temporomandibular disorders
- Transplant evaluation, pre-determination, inpatient admits
- Uterine fibroid ablation, MRI guided high intensity focused ultrasound
- Uvulopalatopharyngoplasty
- Vagus nerve stimulation
- Varicose vein (lower extremity) treatment
- Wheeled mobility devices, ultra lightweight manual wheelchairs

Behavioral Health Services

- Inpatient and Outpatient Mental Health/Substance Abuse (in-network/out-of-network) within 24 hours of admission

Note: Residential Treatment Centers for Mental Health/Substance Abuse are not covered.

AIM Specialty Health Services

- Radiology – Diagnostic Services (CT scan, CTA, MRA, MRI, PET Scan)
- Cardiac – Diagnostic Services (Echocardiography or Nuclear Cardiology)

- Sleep Testing and Therapy Services
- All Radiation Therapy

Predetermination

Though not required, a Predetermination of Benefits and Medical Necessity review is strongly recommended before incurring medical costs for certain services. A Predetermination of Benefits for additional services, upon a Member or Provider request, is available. All requests should clearly indicate that it is for Predetermination of Benefits.

Your Provider should contact or submit a written request to BCBSGa at the address on your ID card. The request should include a complete description of the proposed treatment plan including medical codes and charges, anticipated date of service, and tax identification number for the Provider rendering the service.

BCBSGa will review the Predetermination request and determine eligibility of services. A written determination to your health care Provider and you will indicate whether the services are considered Covered Services and whether the fees are within the Maximum Allowed Amount.

The following are some examples of services (but not limited to):

- Pre-Surgery/Pre-admission Testing
- Infertility Services (Once diagnosed, treatment is not covered)
- Treatment by assistant surgeons or co-surgeons
- Treatment of TMJ
- Allergy testing
- Occupational therapy
- Speech therapy
- Physical therapy
- Reconstructive services

No Precertification on file

If claims are not pre-certified they will be denied for no Precertification. Once information is received, claims can be re-opened based on medical information provided when received within the Appeals timeframe.

Not Medically Necessary

Any services or days determined to be not Medically Necessary will not be covered.

Late Notice

For In-Network Providers, late notice penalties do not apply to Members. For Out-of-Network Providers, the Member penalty is 50% of the Maximum Allowed Amounts for Covered Services.

DISCLAIMER: Read your SPD carefully regarding Covered Services. If you are not sure if a service is covered and requires Precertification, please call Member Services at 855-641-4862. Non-Prior Authorization could result in reduction in payment or non-payment. For In-Network Providers, late notice penalties do not apply to Members. For Out-of-Network Providers, the Member penalty is 50% of the Maximum Allowed Amount for Covered Services. Prior Authorization does not guarantee eligibility or payment.

VOLUNTARY INCENTIVE PROGRAMS

AIM Imaging Cost & Quality Program

The Plan has selected this innovative Imaging Cost & Quality Program for Members through AIM Specialty Health. This Program provides you with access to important information about imaging services you may need. If you need an MRI or a CT scan, it is important to know that costs can vary depending on where you receive the service. Sometimes the difference is significant. The cost can range anywhere from \$300 to \$3000 (a higher price doesn't guarantee higher quality). When your Benefits require you to pay a portion of this cost (Deductible or Co-insurance), where you go can make a big difference in your out-of-pocket costs.

This is where the AIM Imaging Cost & Quality Program comes in. AIM does the research for you to help you find the right location for your MRI or CT scan. Here is how the Program works:

- Your Doctor refers you to a radiology Provider for an MRI or CT scan.
- AIM will work with your Doctor to help make sure that you are receiving the right test – using evidence-based guidelines.
- AIM reviews the Referral to see if there are other Providers in your area that are high quality, but at a lower price.
- If AIM finds another Provider that meets the quality and price criteria, AIM will contact you.
- You have the choice – you can see the radiology Provider your Doctor referred OR you can choose to see a Provider that AIM chooses for you. AIM will help you schedule an appointment with the new Provider.

The AIM Imaging Cost & Quality Program gives you the opportunity to reduce your health care expenses by selecting high quality, lower cost Providers or locations. No matter which Provider you choose, there is no effect on your health care Benefits. However, if you use AIM Imaging Cost & Quality Program you may lower your out-of-pocket expenses. This information is provided to you regarding this program to help you make informed choices about where to go when you need this type of medical care.

Individual Case Management

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Medical Claims Administrator's programs coordinate Benefits and educate Members who agree (at no cost to you) to take part in the Case Management Program to help meet their health-related needs. Case Management programs are confidential and voluntary.

If you meet program criteria and agree to participate, the Medical Claims Administrator will assist you to 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, the Medical Claims Administrator may help with 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.

24/7 Nurse Line

The 24/7 Nurse Line is available by phone 24 hours a day via a toll-free number at 866-787-6361. You will receive instant health care information. Also registered nurses can talk with you about your general health issues and help you determine if you can treat your issue at home, if you need to make an appointment to see your doctor or if you should head to urgent care or the emergency room. Consult with registered nurses on the 24/7 Nurse Line.

Participate in the Personal Health Coach program

If you or another covered family member have certain conditions, the Personal Health Coach can help you better manage your health and follow your doctor's care plan.

Specific conditions include, but are not limited to:

- Asthma: pediatric and adult
- Diabetes pediatric and adult
- Chronic obstructive pulmonary disease
- Heart failure
- Coronary artery disease
- Cancer
- Low Back Pain
- Vascular disease

They can also help you:

- Enroll in the Disease Management (DM) Pharmacy Co-Insurance Waiver Program
- Develop a plan of care so you can better manage your medical condition
- Choose the medical services that are best for you
- Get help setting appointments for routine checkups and exams (preventive care)
- Talk about a diagnosis you got from a doctor and the treatment options you have
- Coordinate your health care benefits before, during, and after a hospital stay

It's easy to connect. SHBP Members can call 866-901-0746. This program is available between 8:00 am to 6:00 pm, Monday through Friday. Everything you talk about is confidential.

Future Moms

Future Moms offers helpful tools during your pregnancy. You can consult with a Personal Health Maternity Nurse by phone 24 hours a day via a toll-free number at 1-866-901-0746, option 2. You will receive support during your pregnancy, screening for risk of depression or early delivery, and more. You may also receive *Your Pregnancy Week by Week* book by participating in this program.

Disease Management (DM) Pharmacy Co-Insurance Waiver Program

Blue Cross Blue Shield of Georgia (BCBSGa) and Express Scripts have a Disease Management (DM) Pharmacy Co-insurance Waiver Program. Pharmacy cost shares for certain prescription drugs will be waived for Members who actively participate in this program. The goal is to encourage Members to actively work on managing their condition and their overall health.

All Members enrolled in the Gold, Silver or Bronze HRA options who are diagnosed with one or more of the following three conditions are eligible to participate in this program:

- Diabetes
- Coronary Artery Disease (CAD)
- Asthma

Members must actively participate in a Disease Management program, as confirmed by the BCBSGa Personal Health Coach (PHC), and complete the following:

- ✓ Complete the Health Information Profile (assessment) with a BCBSGa Personal Health Coach.
- ✓ Complete the Healthways Well-Being Assessment (Healthways is the Wellness Program Administrator providing Lifestyle Management Coaching to SHBP Members. The Well-Being Assessment® is a confidential, online questionnaire that will take the Member about 20 minutes to complete).
- ✓ Actively participate in scheduled coaching calls with a BCBSGa Personal Health Coach (minimum one call each calendar month).

If you have Diabetes, Asthma and/or CAD and are interested in participating in the Personal Health Coach Program and to learn more about how to qualify, please call BCBSGa Member Services at 855-641-4862.

WHAT IS COVERED

This Section gives additional detail on many of the Covered Services outlined in the "Schedule of Benefits" Section table. Your Covered Services are subject to all the terms and conditions listed in this SPD, including, but not limited to, Benefit Maximum, Deductibles, Co-insurance, Exclusions and Medical Necessity requirements. Be sure to read the "How Your Plan Works" Section for more information on your Plan's rules. The "What's Not Covered" Section describes important details on Excluded Services. The Section "Getting Approval for Benefits" describes the processes used to determine if a request is a Covered Service.

Please note that several Sections may apply to your claims as noted above. For example, if you have a surgery, Benefits for your Hospital stay will be described under "Inpatient Hospital Care," and Benefits for your Doctor's services will be described under "Inpatient Professional Service". As a result, you should read all the Sections that might apply to your claims for all services provided.

Additional detail regarding Covered Services are described below:

Ambulance Services (Air, Water, and Ground)

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 /injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of accident or medical Emergency to a Hospital;
 - Between Hospitals, including when the Medical Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when the Medical Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews. Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility. You must be taken to the nearest Facility that can give care for your condition. In certain cases the Medical Claims Administrator may approve Benefits for transportation to a Facility that is not the nearest Facility.

When using an air ambulance, the Medical Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider selected, the Out-of-Network Provider may bill you for any charges that exceed the Maximum Allowed Amount.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service which include, but are not limited to, trips to a:

- a) Doctor's office or clinic;
- b) morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and the first Hospital cannot give you the medical services you need. Certain specialized services are not available at some Hospitals such as burn care, cardiac care, trauma care, and critical care. To be covered, you must be taken to the closest Hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

Autism Services Expansion

Your Plan includes coverage for the treatment of neurological deficit disorders as required by Law. Effective January 1, 2015 limited coverage for medically necessary Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) will be provided to a maximum benefit of \$35,000 per year per approved member (through age 10). Applicable Deductibles and/or Co-Insurance may apply to all covered services.

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.

Note: The Benefit Maximum for cardiac therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.

Chemotherapy

The treatment of an illness by chemical or biological antineoplastic agents. See the Section "Drugs Ordered and Administered by a Medical Provider" for more details.

Chiropractic Services / Osteopathic Manipulation Therapy

Benefits are available for chiropractic treatments (20 visits per Benefit Period) provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.

Note: Chiropractic Services and Osteopathic Manipulation Therapy includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Clinical Trials including Cancer Clinical Trial Programs for Children

Benefits include coverage for services 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 subsections below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs
 - ii. The Department of Defense
 - iii. The Department of Energy
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your Benefits. When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trial services that are not part of approved clinical trials will be reviewed according to the Medical Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide Benefits for the following services and reserves the right to exclude any of the following services:

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

Cancer Clinical Trial Programs for Children

Covered Services include routine patient care costs incurred in connection with the provision of goods, services, and Benefits to Members who are Dependent children in connection with approved clinical trial programs for the treatment of children's cancer. Routine patient care costs mean those Medically Necessary costs as provided in Georgia law (O.C.G.A. § 33-24-59.1).

Dental Services & Oral Surgery

Note: This Plan provides limited coverage for dental services and oral surgery.

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy and to treat oral cancer as well as repair (or replace) damage by effects of radiation treatment and for oral cancer preparation for transplants.

Covered Services in these circumstances include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Other Dental Services

Hospital or Facility charges and anesthesia needed for dental care are covered if the Member meets any of the following conditions:

- The Member is under the age of 7
- The Member has a chronic disability that is attributable to a mental and/ or physical impairment which results in substantial functional limitation in an area of the Member's major life activity, and the disability is likely to continue indefinitely; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care

Oral Surgery

Note: This Plan provides limited coverage for certain oral surgeries. Many oral surgical procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

- Reconstructive surgical procedures (including dental implants) for the repair of sound, natural teeth or tissue that were damaged as a result of oral cancer or treatment for oral cancer such as chemotherapy or radiation treatment and other cancer related treatments with prior approval by the Precertification unit.
- 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 as indicated in the above "Dental Services"
- Treatment of non-dental lesions, such as removal of tumors and biopsies
- Incision and drainage of infection of soft tissue (except for odontogenic cysts or abscesses are not covered)

Diabetes Equipment, Education, and Supplies

Covered Services for the treatment of diabetes include medical supplies, services, equipment, and diabetes self-management education programs.

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin 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 provision, 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.

For additional information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" in this Section and in "What's Covered" Section. For information on Prescription Drug coverage, please refer to the "Outpatient Prescription Drug Rider" in this SPD.

Diagnostic Services

Your Plan includes Benefits for medically necessary tests or procedures to find or check for a when specific symptoms exist and include diagnostic services ordered before a surgery or Hospital admission. Tests must be ordered by a Provider. 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
- Tests ordered before a surgery or hospital admission

Other Imaging Services

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

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

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

Dialysis / Hemodialysis & Specialty Care Physician

Evaluation and Management of acute renal failure and chronic (end-stage) renal disease, including treatment by 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 and home dialysis and training for you and the person who will help you with home self-dialysis.

Drugs Administered and Billed by a Provider as a Medical Service

Your Plan covers Drugs when these are administered to you as part of a Doctor's visit, home care visit, or at an outpatient Facility when your Provider bills under the medical benefits. This includes drugs for infusion therapy, chemotherapy, certain specialty drugs, blood products, and office-based injectables. Certain drugs require Precertification or Prior Approval.

Note: Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by BCBSGa. The Prescription Drug Benefits which include retail, home delivery and specialty drug programs are administered by Express Scripts. See refer to the "Outpatient Prescription Drug Rider" in this SPD.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

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 use of the patient; is made to serve a medical use; and is ordered by a Provider.

Medically necessary Covered Services include:

- The 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)
- Continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by the Medical Claims Administrator. The Plan may limit the amount of coverage for ongoing rental of equipment. The Plan may not cover more in rental costs than the cost of simply purchasing the equipment.
- The repair and replacement costs as well as 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
- Cochlear implants
- Breast pumps (as described in the “Preventive Care” Section)
- Medical equipment and medical supplies for the treatment of diabetes
- Hearing aids (as described in the “Schedule of Benefits” Section)

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).

Orthotics

Benefits are available for certain types of orthotics (braces, boots, and splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, (or correct) deformities; or to improve the function of movable parts of the body which limits or stops motion of a weak or diseased body part.

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.

Medically necessary Covered Services include:

- The fitting, adjustments, repairs and replacements of prosthesis
- 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 the Women’s Health and Cancer Rights Act
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care
- Restoration prosthesis (composite facial prosthesis)

- Wigs needed after cancer/chemotherapy treatment, limited to the \$750 lifetime maximum shown in the “Schedule of Benefits” Section

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).

Emergency Room Services

Emergency Services

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

Emergency / Emergency Medical Condition

“Emergency,” or “Emergency Medical Condition” means a medical 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 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, cuts, uncontrolled bleeding, seizures, and such other acute conditions as may be determined to be Emergencies by the Medical Claims Administrator.

Emergency Care

“Emergency Care” means a medical examination done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It also includes any further medical examination(s) and/or treatment(s) required to stabilize the patient.

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

Medically Necessary services will be covered whether you receive care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. You may have to pay the difference between the Out-of-Network Provider’s charge and the Maximum Allowed Amount, as well as any applicable Co-insurance, or Deductible.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amounts already negotiated with BCBSGa’s In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method BCBSGa generally uses to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing provisions; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor call the Medical Claims Administrator as soon as possible. The Medical Claims Administrator will review your care & determine if the Hospital admission and length of stay is a covered service. See “Getting Approval for Benefits” for more details. If you or your Doctor do not call the Medical Claims Administrator, 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 be covered at the Out-of-Network level

unless the Medical Claims Administrator agrees to cover it as an Authorized Service.

Habilitative Services

Benefits also include habilitative 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:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Home health services. Home health services are limited to skilled nursing or therapy services provided in the home that are prescribed to achieve specific health care goals. Covered home health services must be provided by professional health personnel such as registered nurses, licensed practical nurses, occupational therapists, physical therapists, speech pathologists or audiologists. The prescribing provider must update the home health treatment plan at least once every 30 days to define the continued need for skilled intervention. Home health services do not include custodial care. Custodial care generally provides assistance in performing activities of daily living (e.g., assistance walking, transferring in and out of bed, bathing, dressing, using the toilet, preparation of food, feeding and supervision of medication that usually can be self-administered). Custodial care essentially is personal care that does not require the attention of trained medical or paramedical personnel.
- Home Infusion Therapy– includes Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See Section "Drugs Administered and Billed by a Provider as a Medical Service" for more details.

Hospice Care

Your Doctor and Hospice medical director must certify that you are terminally ill and probably have less than 12 months to live. Your Doctor must agree to Hospice care and must be consulted in the development of the treatment plan. The Hospice must keep a written care plan on file and give it to the Medical Claims Administrator upon request.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means

care that controls pain and relieves symptoms, but is not meant to cure a terminal illness.

Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse
- Social services and counseling services from a licensed social worker
- Nutritional support, such as intravenous feeding and feeding tubes
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, (both before and after the Member's death). Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care

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

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. A Covered Transplant Procedure is defined as the determination by the Medical Claims Administrator, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions (including necessary acquisition procedures, mobilization, harvest and storage). It also, includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

The Medical Claims Administrator has a Centers of Excellence (COE) Network selected to give specific services to Members. Members must use a Blue Distinction Center for Transplants (BDCT) or one of the Center of Medical Excellence (CME) Transplant Network facilities to receive benefits for transplant services:

- Blue Distinction Center for Transplant (BDCT) The Blue Distinction Centers for Specialty CareSM is a program administered by the Blue Cross and Blue Shield Association that identifies quality providers for transplant services nationwide. Each Center has been selected through a rigorous evaluation of clinical data that provides insight into the facility's structures, processes, and outcomes of care.
- Centers of Medical Excellence (CME) The CME designation is awarded by BCBS to those programs meeting the participation requirements for BCBS's transplant network and all other future specialty networks developed by BCBS. Each Center has been selected through a rigorous evaluation of clinical data that provides insight into the facility's structures, processes, and outcomes of care.

Precertification and Prior Approval for Transplant Services

Precertification and Prior Approval are required (except for kidney & cornea) before the Plan will cover Benefits for a transplant. To maximize your Benefits, call BCBSGa's Transplant Department as soon as you think you may need a transplant, before evaluation and/or workup, and to talk about your benefit options. The Transplant department will help you maximize your Benefits by giving you

coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Member Service phone number on your Member ID Card and ask for the transplant coordinator. Your Doctor must certify, and the Medical Claims Administrator must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to the Medical Claims Administrator as soon as possible to start this process. Failure to obtain Precertification will result in a denial of Benefits.

Even if you are given a prior approval for the Covered Transplant Procedure, you or your Provider must call the Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Note: There are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges are covered as diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity, and a coverage determination made. In an approval determination for HLA testing, donor search and/or harvest and storage; however, is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits for Transplant Services

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered Members under this Plan, each will get Benefits under their plan.
- When the person getting the organ is a covered Member under this Plan, but the person donating the organ is not, Benefits under this Plan are limited to Benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If a covered Member under this Plan is donating the organ to someone who is not a covered Member, Benefits are not available under this Plan.

Transportation and Lodging for Transplant Services

The Plan will cover the cost of reasonable and necessary travel costs (when you get prior approval), and need to travel more than seventy-five (75) miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Assistance with travel costs includes transportation to and from the Facility, with lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs to the Medical Claims Administrator when claims are filed. Call the Medical Claims Administrator for complete information.

For lodging and ground transportation Benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code, but not to exceed \$10,000 per transplant episode. The Internal Revenue Code can be found at www.irs.gov/pub/irs-drop/n-13-80.pdf. For 2015, the standard mileage rate is 23.5 cents per mile for use of an automobile (1) for medical care described in § 213.

Non-Covered Services for transportation and lodging for transplant services include, but are not limited to: child care, mileage within the medical transplant Facility city, rental cars, buses, taxis, or shuttle service (except as specifically approved by the Medical Claims Administrator), frequent flyer miles, coupons, vouchers or travel tickets, prepayments or deposits, services for a condition that is not directly related to or a direct result of the transplant, phone calls, laundry, postage, entertainment, travel costs for donor companion/caregiver, return visits for the donor for a treatment of an illness found during the evaluation, and meals.

NOTE: Travel and Lodging reimbursement is also available for eligible members when receiving cancer treatment at an eligible Cancer Resource Service Center of Excellence* (COE). The member's home address must be at least 100 miles from the COE (200 miles for airfare). All eligible expenses are reimbursed after the Expense Forms have been completed and submitted with the appropriate receipts. All other guidelines follow those outlined above under Transportation and Lodging for Transplant Services.

Inpatient Facility Services

Inpatient Hospital Care

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

- A room with two or more beds
- A private room. The most the Plan will cover for a private room 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 the Medical Claims Administrator. 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

Benefits for ancillary services include:

- 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 examination by a 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

Maternity and Reproductive Health Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. 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 and postnatal services
- Medically Necessary fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, Benefits for obstetrical care will be **available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form** and send it to the Medical Claims Administrator. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period. If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.

Note about Maternity Admissions: Under federal law, the Plan 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, the Plan may not require a Provider to get authorization 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 are available for contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. Please see "Preventive Care" Section for regarding certain contraceptives for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Please see "Preventive Care" Section for regarding sterilization services for further details.

Abortion Services

Benefits include services for an abortion recommended by a Provider when performed to save the life of the mother.

Infertility Services

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). Diagnostic services are covered to rule out a diagnosis, but once diagnosed; treatment of infertility is not covered. This Plan does not offer any form of infertility treatment.

Note: Coverage for Infertility drugs may be approved for a medical diagnosis not related to infertility treatment when the medical diagnosis meets the definition of a Covered Service and is not an Experimental, Investigational, or Unproven Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient Benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification or outpatient facility, such as partial hospitalization programs and intensive outpatient programs.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital and office visits.

You can get Covered Services from the following Providers:

- Psychiatrist
- Psychologist
- Neuropsychologist
- 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)
- Any agency licensed to provide these services, when they must be covered by law

Office Visits and Physician Services

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

Walk-In Doctor's Office for services limited to routine care and the 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.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that a Doctor visit in the home is different than the "Home Care Services" benefit described earlier in this SPD.

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 the treatment of common illnesses for adults and children.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital
- Freestanding Ambulatory Surgical Facility
- Mental Health / Substance Abuse Facility
- Other Facilities approved by the Medical Claims Administrator

Benefits include Facility and related (ancillary) charges, when proper, 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

Physical Medicine Therapy Services (Physical, Occupational and Speech Therapy)

For Early Intervention Services, Benefits are available for the care and treatment of congenital defects and birth abnormalities for covered children without regard to whether the condition is acute or chronic, and also without regard to whether the purpose of the therapy is to maintain or improve functional capacity. From the Member's birth until the Member's third (3rd) birthday, these early intervention services shall be provided only to the extent required by law. From the Member's birth until the Member's sixth (6th) birthday, Benefits are allowed up to the maximum visits listed in the "Schedule of Benefits" for physical, speech and occupational therapies.

For all other Members (e.g., those six (6) and older, or who do not qualify for the Benefits above),

Benefits are provided only if the physical, speech or occupational therapy are Medically Necessary and will result in a practical improvement in the level of functioning within a reasonable period of time.

The limit for physical therapy, speech therapy, and occupational therapy will not apply when you receive this care as part of Hospice Care or at an Inpatient Facility.

Benefits for physical, speech or occupational therapy as detailed below are allowed up to the maximum visits listed in the "Schedule of Benefits". 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 leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.

Note: Physical Therapy benefits may be extended beyond 40 visits for children up to age 19 with Congenital Anomalies that require surgical correction. The child will also have to be enrolled in case management and meet medical necessity criteria.

- 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 swallowing skills or communication 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 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.

Preventive Care

Preventive Care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem. Preventive care services must meet the requirements of federal and state law. Certain Preventive care services are covered with no Deductible or Co-insurance when you use an In-Network Provider and the service is properly coded as preventive care. That means the Plan covers 100% of the Maximum Allowed Amount.

Covered Services include the following:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
 - Breast cancer
 - Cervical cancer
 - Colorectal cancer
 - High blood pressure
 - Type 2 Diabetes Mellitus
 - Cholesterol
 - Child and adult obesity
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - Women's contraceptives, sterilization procedures and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs) and implants.

- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
 - Gestational diabetes screening
5. The following services required by state and federal law:
- Lead poisoning screening for children
 - Routine mammograms
 - Routine colorectal cancer examination and related laboratory tests
 - Chlamydia screening
 - Ovarian surveillance testing
 - Pap smear
 - Prostate screening
 - Appropriate and necessary childhood immunizations that meet the standards approved by the U.S. public health service for such biological products against at least all of the following:
 - Diphtheria
 - Pertussis
 - Tetanus
 - Polio
 - Measles
 - Mumps
 - Rubella
 - Hemophilus influenza b (Hib)
 - Hepatitis B
 - Varicella
 - Additional immunizations will be covered per federal law, as indicated earlier in this Section

You may call BCBSGa Member Services at the number on your Member ID 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>, and
<http://www.cdc.gov/vaccines/acip/index.html>

Note: Services for an illness or injury including diagnostic services are not covered under the Preventive benefit.

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, and treatment planning.

Rehabilitation Services

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals. Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

Respiratory 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 airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Prescription Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Pulmonary Rehabilitation – Includes outpatient short-term respiratory care to restore your health after an illness or injury.

Note: The Benefit Maximum for cardiac therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.

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 and facilities Out-of-Network are not a Covered Service.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries.

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

Reconstructive Surgery

Benefits include reconstructive surgery performed 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: See the “Women’s Health and Cancer Rights Act of 1998” in the “Additional Federal Notices” Section for details regarding mastectomy including reconstruction.

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.

Note: Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Urgent Care Services

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 such as:

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

Vision Services

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit. Benefits do not include glasses and contact lenses except as listed in the "Prosthetics" benefit.

WHAT IS NOT COVERED

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.

1. **Abortion** Services, supplies, Prescription Drugs, and other care provided for elective voluntary abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions performed to save the life of the mother.
2. **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond the Medical Claims Administrator's control, the Medical Claims Administrator will make a good faith effort to give you Covered Services. The Medical Claims Administrator will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience. This Exclusion does not apply to acts of terrorism.

3. **Administrative Charges**
 - Charges for the completion of claim forms,
 - Charges to get medical records or reports,
 - Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
4. **Alternative/Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - Acupuncture,
 - Holistic medicine,
 - Homeopathic medicine,
 - Hypnosis,
 - Aromatherapy,
 - Massage and massage therapy,
 - Reiki therapy,
 - Herbal, vitamin or dietary products or therapies,
 - Naturopathy,
 - Thermography,
 - Orthomolecular therapy,
 - Contact reflex analysis,
 - Bioenergetic synchronization technique (BEST),
 - Iridology-study of the iris,
 - Auditory integration therapy (AIT),
 - Colonic irrigation,
 - Magnetic innervation therapy,
 - Electromagnetic therapy,
 - Neurofeedback / Biofeedback.
5. **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 Plan.

6. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
7. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
8. **Chiropractic Services / Osteopathic Manipulation Therapy** Services includes, but are not limited to:
 - 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.
 - Nutritional or dietary supplements, including vitamins
 - Cervical pillows
 - Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.
 - Manipulation Therapy is not covered when given in the home
9. **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. This Exclusion does not apply to problems resulting from pregnancy.
10. **Contraceptives** Non-prescription contraceptive devices, unless required by law.
11. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No Benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or surgery to restore function of any body area that has been altered by illness or trauma.
12. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
13. **Crime** Treatment of injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
14. **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
15. **Dental Treatment** Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as:
 - Removing, restoring, or replacing teeth;
 - Medical care or surgery for dental problems (unless listed as a Covered Service in this SPD);
 - Services to help dental clinical outcomes.

This Exclusion does not apply those services required by the law to be covered.
16. **Dental Services** Dental services not described as Covered Services in this SPD.
17. **Donor Breast Milk**

18. **Educational Services** or supplies for teaching, vocational, or self-training purposes, including Applied Behavior Analysis (ABA), except as listed in this SPD for prior approved ABA for Autism Spectrum Disorders for covered dependents ages 10 and under.
19. **Experimental or Investigational Services or supplies** that are found to be Experimental/ Investigational. This also applies to services related to Experimental/Investigational services, whether you get them before, during, or after you get the Experimental/Investigational service or supply. The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Medical Claims Administrator deems it to be Experimental / Investigative.
20. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight. This Exclusion does not apply to lenses needed after a covered eye surgery.
21. **Eye Exercises** Orthoptics and vision therapy.
22. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
23. **Family Members** Services prescribed, ordered, referred by or given by a Member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
24. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
 - Cleaning and soaking the feet.
 - Applying skin creams to care for skin tone.
 - Other services that are given when there is not an illness, injury or symptom involving the foot.
25. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.
26. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
27. **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Worker's Compensation Benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the Benefits in whole or in part. This Exclusion also applies whether or not you claim the Benefits or compensation, and whether or not you get payments from any third party.
28. **Gynecomastia** Treatment of benign gynecomastia (abnormal breast enlargement in males).
29. **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 Doctor. This Exclusion also applies to health spas.
30. **Home Care**
 - Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a home health care Provider.
 - Food, housing, homemaker services and home delivered meals.
31. **Infertility Treatment** Testing or treatment related to infertility except for diagnostic services and

procedures to correct an underlying medical condition. Non-covered service includes assisted reproductive technologies (ART) or the diagnostic tests and Prescription Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT). Fertility treatments such as artificial insemination and in-vitro fertilization, egg and sperm storage/preservation for future pregnancy. Other Infertility procedures not specified in this SPD are not Covered Services.

32. **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

33. **Medical Equipment and Supplies**

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Non-Medically Necessary enhancements to standard equipment and devices.

34. **Medicare** Services for which Benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except, as listed in this SPD or as required by federal law, as described in the Section titled "Medicare" in the "General Provisions" Section. If you do not enroll in Medicare Part B, the Medical Claims Administrator will calculate Benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs. For Medicare Part D the Medical Claims Administrator will calculate Benefits as if you had enrolled in the Standard Basic Plan.

35. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

36. **Non-Covered Providers** Examples of Non-Covered Providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

37. **Non-Medically Necessary Services** As determined by the Medical Claims Administrator. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.

38. **Nutritional Formulas or Dietary Supplements** Nutritional/Enteral formulas including infant formula, dietary and electrolyte supplements. This exclusion includes, but is not limited to, *nutritional formulas and supplements that you can buy over the counter* and those you can get without a written prescription or from a licensed pharmacist.

Enteral feedings are not covered except if it is the sole source of nutrition or for inborn errors of metabolism except for those pre-approved through BCBSGa case management and meet the Medical Claims Administrator's Clinical Guideline for coverage.

39. **Oral Surgery Extraction of teeth, surgery for impacted teeth** and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this SPD.

40. **Personal Care and Convenience**

- Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs;
- First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads);
- Home work out or therapy equipment, including treadmills and home gyms;
- Pools, whirlpools, spas, or hydrotherapy equipment;
- Hypo-allergenic pillows, mattresses, or waterbeds; or
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

41. **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy. Pharmacy Benefits are administered separately. See the "Prescription Drug Pharmacy Benefits" table in this Section and the "Outpatient Prescription Drug Rider" Section of the SPD for more information.
42. **Private Duty Nursing** Private Duty Nursing Services.
43. **Prosthetics** for sports or cosmetic purposes.
44. **Routine Physical Exams** Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, or for school activities.
45. **Sex Change** Services and supplies for a sex change, gender reassignment and/or the reversal of a sex change.
46. **Sexual Dysfunction** Services or supplies for male or female sexual problems.
47. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
48. **Sterilization** Reversals of elective sterilizations are not covered. This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that Section for further details.
49. **Surrogate Mother Services** or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
50. **Tobacco Cessation Programs** to help you stop using tobacco if the program is not affiliated with BCBSGa or Healthways (the SHBP Wellness vendor).
51. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
52. **Vein Treatment** of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
53. **Vision Services** Vision services not described as Covered Services in this SPD.
54. **Weight Loss Programs**, whether or not under medical supervision. This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
55. **Weight Loss Surgery** Bariatric surgery (except for those 75 randomly selected non-Medicare Advantage pilot members in the Bariatric Surgery Pilot Program). Non-covered services includes but are not limited to Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower 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, (surgeries that reduce stomach size), or gastric banding procedures.

MEDICAL CLAIMS PAYMENT

This Section describes how the Medical Claims Administrator reimburses claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network hospitals, Doctors and other Providers will still submit your claim for you, although they are not required to do so. If you submit the claim, use a claim form as described later in this Section.

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

Maximum Allowed Amount

This Section describes how the Medical Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see "Out-of-Network Services" later in this Section for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement this Plan will allow for Covered Services:

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

For Covered Services, you will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or Co-insurance. In addition, when you receive Covered Services from an Out-of-network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges (balance billing). This amount can be significant.

When you receive Covered Services from an eligible Provider, the Medical Claims Administrator 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 the determination of the Maximum Allowed Amount. The application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Medical Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, a Provider may submit a 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, the Maximum Allowed Amounts may be reduced 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 Plan or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the Medical Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as your 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 Co-insurance. Please call Member Services for help in finding an In-Network Provider or visit www.bcbsga/shbp.com.

Providers who have not signed any contract with the Medical Claims Administrator, and are not in any of the Medical Claims Administrator's networks are Out-of-Network Providers, (subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers).

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

1. An amount based on the Medical Claims Administrator Out-of-Network fee schedule/rate, which the Medical Claims Administrator has established in its discretion, which the Medical Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: (i) reimbursement amounts accepted by like/similar Providers contracted with the Medical Claims Administrator; (ii) reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, and (iii) reimbursement and utilization data.
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, the Medical Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually.
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.
4. An amount negotiated by the Medical Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Note: Providers who are not contracted for your Plan, but are contracted for the Medical Claims Administrator's indemnity product are considered Non-Preferred. In your Plan, the Maximum Allowed Amount for services from these Providers will be one of the five (5) methods shown above unless the contract between the Medical Claims Administrator and that Provider specifies a different amount. In this case, Non-Preferred Providers may not send you a bill and collect for the amount of the Non-Preferred Provider's charge that exceeds the Maximum Allowed Amount for Covered Services.

Unlike In-Network Providers, Out-of-Network Providers may bill and collect for the amount of the Provider's charge that exceeds the 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 result in lower out-of-pocket costs to you.

Member Services is also available to assist you in determining your plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order 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 services rendered at the time of service and the claim submitted by the Provider.

For Out-of-Network Providers, your Plan does not accept assignment of Benefits. You will receive a payment of Benefits for Covered Services and it will be your responsibility to pay that to the Out-of-Network Provider.

Member Cost Share

For Covered Services you will be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible and Co-insurance).

Your cost share amount and Out-of-Pocket Maximum may vary depending on whether you received services from an In-Network or Out-of-network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your Benefits when using Out-of-Network or Non-Preferred Providers. See "Schedule of Benefits" Section in this SPD for your cost share responsibilities and limitations, or call Member Services to learn how this Plan's Benefits or cost share amounts will vary by the network status of the Provider you use.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan, and services received after Benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your Lifetime Maximum, benefit caps or day/visit limits.

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

Authorized Services for Out-of Network Providers

In some circumstances, such as when there is no In-Network Provider available for the Covered Service, your plan may authorize the In-Network cost share amounts (Deductible, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In these circumstances, you must contact the Medical Claims Administrator prior to receiving the Covered Service. You may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge

Your plan 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 the Medical Claims Administrator until after the Covered Service is rendered. If your plan authorizes 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 to obtain authorization or to request information on Authorized Services.

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the 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.

Notice of Claim & Proof of Loss

After you get Covered Services, the Medical Claims Administrator must receive written notice of your claim within twelve (12) months in order for Benefits to be paid. The claim must have the information needed to determine Benefits. If the claim does not include enough information, the Medical Claims Administrator will ask for more details and it must be sent in order for Benefits to be paid, except as required by law. 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 certain cases, you may have some extra time to file a claim. If the Medical Claims Administrator did not receive your claim within ninety (90) calendar days, but it is sent in as soon as reasonably possible and within one year after the ninety (90) day period ends (i.e. within fifteen (15) months), you may still be able to get Benefits.

Note: Any claims, or additional information on claims, sent in more than twenty-four (24) months after you get Covered Services will be denied.

Your claim will be processed and any payment of claims will be made as soon as possible following receipt of the claim. Any Benefits payable for Covered Services will be paid within fifteen (15) business days for electronic claims; or thirty (30) calendar days for paper claims (unless more time is required because of incomplete or missing information). In this case, you will be notified within fifteen (15) business days for electronic claims; or thirty (30) calendar days for paper claims of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, the Medical Claims Administrator has fifteen (15) business days to complete claims processing for electronic claims; or thirty (30) calendar days for paper claims. Any portion of your claim that does not require additional information will be processed according to the timeframes outlined above. BCBSGa shall pay the interest at the rate of twelve percent (12%) per year by BCBSGa to you or the assigned Provider if it does not meet these requirements.

Medical Claim Forms

Medical claim forms will usually be available from most Providers. If forms are not available, visit BCBSGa website at www.bcbsga/shbp.com or Member Services and ask for a claim form to be sent to you. If you do not receive the claim form, written itemization and description of services rendered may be submitted without the medical claim form. The same information that would be given on the claim form must be included in the written notice of claim.

This includes:

- Member ID
- Name of patient
- Patient's relationship with the Covered Person
- Date, type, and place of service
- Your signature and the Provider's signature

Payment of Benefits

The Medical Claims Administrator may make benefit payments directly to In-Network Providers for Covered Services. If you use an Out-of-Network Provider, the Medical Claims Administrator may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to an Alternate Recipient (for any child of a Covered Person who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Plan), or that person's custodial parent or designated representative. You cannot assign your right to Benefits to anyone else, except as required by a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, the Medical Claims Administrator will not honor a request to withhold payment of the claims submitted.

Out-of-Area Services

Blue Cross and Blue Shield Healthcare Plan (BCBSHP) has relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain Covered Services outside of BCBSHP's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program, and may include negotiated National Account arrangements available between BCBSHP and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside BCBSHP's service area, you will obtain care from other Providers that have a contractual agreement (i.e., "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating Providers. BCBSHP's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSHP will remain responsible for fulfilling BCBSHP's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside BCBSHP's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSHP uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, your liability for any covered healthcare services would then be calculated according to applicable law.

You will be entitled to Benefits for healthcare services that you accessed either inside or outside the geographic area BCBSHP serves, if this Plan covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to Benefits for some healthcare services obtained outside the geographic area BCBSHP serves, even though you might not otherwise have been entitled to Benefits if you had received those healthcare services inside the geographic area BCBSHP serves. But in no event will you be entitled to Benefits for healthcare services, wherever you received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

Non-Participating Providers outside the Medical Claims Administrator's Service Area

Member Liability Calculation

When Covered Services are provided outside of the Medical Claims Administrator's Service Area by non-participating Providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, the Medical Claims Administrator may use other payment bases, such as billed covered charges, the payment the Plan would make if the healthcare services had been obtained within the Medical Claims Administrator's service area, or a special negotiated payment as permitted under Inter-Plan Programs Policies, to determine the amount the Plan will pay for services rendered by non-participating healthcare Providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered non-network care, and you may be billed the difference between the charge and the Maximum Allowed Amount. You may call BCBSGa Member Services on your Member ID card or go to www.bcbsga/shbp.com for more information about such arrangements.

COORDINATION OF BENEFITS WHEN MEMBERS ARE INSURED UNDER MORE THAN ONE PLAN

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

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

Please note that several terms specific to this Section are listed below. Some of these terms have different meanings in other parts of the SPD, e.g., Plan. For this provision only, your plan is referred to as "This Plan" and any other insurance plan as "Plan". In the rest of the SPD, Plan has the meaning listed in the "Definitions" Section.

Claim Determination Period means a Benefit Period Year. However, it does not include any part of a year during which you have no coverage under This Plan or any part of a year before the date this "Coordination of Benefits" provision or a similar provision takes effect.

Plan, for the purposes of this Section, means any of the following that provides Benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous twenty-four (24) hour coverage. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan whose Benefits, by law, are in excess to those of any private insurance program or other non-governmental program.
3. "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

Each contract or other arrangement for coverage under 1 or 2 above is a separate Plan. If an arrangement has two parts and these rules apply only to one of the two, each of the parts is a separate Plan.

This Plan means the part of this Plan that provides Benefits for Covered Services.

Primary Plan/Secondary Plan means the "Order of Benefit Determination Rules" states whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering you.

-When This Plan is the Secondary Plan, the Benefits are determined after those of the other plan and may be reduced because of the other plan's Benefits.

-When This Plan is the Primary Plan, the Benefits are determined before those of the other Plan and without considering the other Plan's Benefits.

-When there are more than two Plans covering you, This Plan may be a Primary Plan in relationship to one or more other plans and may be a Secondary Plan in relationship to a different plan or plans.

Order of Benefit Determination Rules

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

- **Automobile Insurance** - Medical Benefits available through automobile insurance coverage will be determined before this Plan.
- **Non-Dependent/Dependent** - The Benefits of the program which covers the person as a Covered Person (other than as a Dependent) are determined before those of the program which covers the person as a Dependent.
- **Dependent Child/Parents Not Separated or divorced** - Except as stated below, when this program and another program cover the same child as a Dependent of different persons, called "parents":
 1. The Benefits of the program of the parent whose birthday falls earlier in a year are determined before those of the program of the parent whose birthday falls later in that year.
 2. If both parents have the same birthday, the Benefits of the program which covered the parent longer will be determined before those of the program which covered the other parent for a shorter period of time.

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

- **Dependent Child/Parents Separated or Divorced** - If two or more programs cover a person as a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:
 1. the program of the parent with custody of the child;
 2. the program of the spouse of the parent with custody of the child; and
 3. the program of the parent not having custody of the child.

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

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

Effect on the Benefits of This Plan

This Section applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a secondary plan to one or more other plans. In that event the Benefits of this Plan may be reduced under this Section. Such other plan(s) are referred to as "the other plans" below.

Reduction in this Program's Benefits

The Benefits of this Plan will be reduced when the sum of:

- the Benefits that would be payable for the Allowable Expenses under this Plan in the absence of this provision; and
- the Benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the Benefits of this Plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses.

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. The Medical Claims Administrator has the right to decide which facts it needs. The Medical Claims Administrator may need to get facts from or give them to any other organization or person, as necessary to coordinate Benefits. The Medical Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must provide any facts needed to pay the claim.

Facility of Payment

A payment made under another program may include an amount which should have been paid under This Plan. If it does, the Medical Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this program. This Plan will not have to pay that amount again.

Right of Reimbursement

If the amount of the payment made by this Plan is more than it should have paid under this provision, the Medical Claims Administrator may recover the excess from one or more of:

- the persons it has paid or for whom it has paid,
- insurance companies, or
- other organizations.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays Benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise.

If you obtain a Recovery, the Plan shall have a right to be repaid from the Recovery in the amount of the Benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of Benefits the Plan paid on your behalf.
- Our right of Recovery shall be limited to the amount of any Benefits paid for covered medical expenses under this program, but shall not include non-medical items.

Your Duties:

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Covered Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, the Medical Claims Administrator is committed to making sure your rights are respected while paying for Covered Services. That also means giving you access to the Network Providers and the information you need to make the best decisions for your health and welfare. BCBSGa is committed to providing quality Benefits and customer service to its Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your Plan, and share your feedback. This includes information on:
 - The Medical Claims Administrator's company and services.
 - The Medical Claims Administrator's network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care plan.
 - The way your Plan works.
- Make a complaint or file an appeal about:
 - Your Plan, or
 - Any care you get, or
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health Benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician (Doctor), also called a PCP.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.
- Give the Medical Claims Administrator, your Doctors and other health care professionals the information needed to help you get the best possible care and all the Benefits you are entitled to. This may include information about other health and insurance Benefits you have in addition to your coverage with the Plan.

For more information call BCBSGa Member Services or go to www.bcbsga/shbp.com.

YOUR RIGHT TO APPEAL

For purposes of these Appeal provisions, 'claim for Benefits' means a request for Benefits under the Plan. The term includes both pre-service and post-service claims:

- A pre-service claim is a claim for Benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for Benefits under the Plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Medical Claims Administrator follows the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Medical Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Medical Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, (along with a discussion of the claims denial decision).
- information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about your right to request this explanation free of charge, (along with a discussion of the claims denial decision)
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you

For claims involving urgent/concurrent care:

- The Medical Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process.
- The Medical Claims Administrator may notify you or your authorized representative within seventy-two (72) hours orally and then furnish a written notification.

Mandatory First Level Appeals (Grievances)

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Medical Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

For pre-service claims involving urgent/concurrent care

You may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Medical Claims Administrator's decision, can be

sent between the Medical Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Medical Claims Administrator at the number shown on the back of your Member ID Card and provide at a minimum:

- the Member ID number for the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of Benefits was sought; and
- reason the appeal should be processed on a more expedited basis.

All other requests for Appeals (Grievances)

Should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral Appeals (Grievances) is otherwise required by the nature of the appeal (e.g., urgent care). You or your authorized representative must submit a request for review to:

BCBSHP, ATTN: Appeals, P.O. Box 105449, Atlanta, GA 30348-5187

Upon request, the Medical Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination;
- was submitted, considered, or produced in the course of making the benefit determination;
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Medical Claims Administrator will also provide you (free of charge) with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Medical Claims Administrator will provide you, free of charge, with the rationale.

For Out of State Appeals (Grievances)

You have to file Provider Appeals with the BlueCard Out of State Plan. This means Providers must file Appeals with the same plan to which the claim was filed. Please contact 855-641-4862 to obtain additional information on the Appeal process for BlueCard providers.

How Your Appeal will be Decided

When the Medical Claims Administrator considers your appeal, the Medical Claims Administrator will not rely upon the initial benefit determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A mandatory second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

- If you appeal a claim involving urgent/concurrent care: the Medical Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than seventy-two (72) hours after receipt of your request for appeal.
- If you appeal any other pre-service claim: the Medical Claims Administrator will notify you of the outcome of the appeal within fifteen (15) days after receipt of your request for appeal.
- If you appeal a post-service claim: the Medical Claims Administrator will notify you of the outcome of the appeal within thirty (30) days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Medical Claims Administrator will include all of the information set forth in the above Section "Notice of Adverse Benefit Determination".

Mandatory Second Level Appeals (Grievances)

If you are dissatisfied with the Plan's mandatory first level appeal decision, a mandatory second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Second Level Appeals (Grievances) must be submitted within sixty (60) calendar days of the denial of the first level appeal. You are required to complete a mandatory second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first and second level appeals are adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to the Medical Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Medical Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Medical Claims Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Medical Claims Administrator's decision, can be sent between the Medical Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Medical Claims Administrator at the number shown on the back of your Member ID Card and provide at least the following information:

- the Member ID number for the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of Benefits was sought; and
- reason the appeal should be processed on a more expedited basis.

Such requests should be submitted by you or your authorized representative to:

BCBSHP, ATTN: Appeals, P.O. Box 105449, Atlanta, GA 30348-5187

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other Benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for other means available through applicable state laws.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for Benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

The Medical Claims Administrator reserves the right to modify the policies, procedures and timeframes in this Section upon further clarification from Department of Health and Human Services and Department of Labor.

GENERAL PROVISIONS

Form or Content of SPD

No agent or Covered Person of the Medical Claims Administrator is authorized to change the form or content of this SPD. Such changes can be made only through an endorsement authorized and signed by an officer of Plan Administrator.

Government Programs

The Benefits under this Plan shall not duplicate any Benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If duplication of such Benefits occurs, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to the Plan.

Medical Policy and Technology Assessment

The Medical Claims Administrator 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 the Medical Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately twenty (20) Doctors from various medical specialties including the Medical Claims Administrator'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.

Medicare

Any Benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, SPD terms, 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, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the Plan, to the extent that payment was made for such services. For the purposes of the calculation of Benefits, if you have not enrolled in Medicare Parts B and/or D the Medical Claims Administrator will pay primary Benefits and Covered Person will pay the unsubsidized premium.

Note: You should enroll in Medicare Part B as soon as possible to avoid paying the unsubsidized rates.

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Plan and receive group Benefits as primary coverage. Also, spouses (regardless of age) of active Employees can remain on the Plan and receive group Benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to your local Social Security Administration office.

Modifications

The Plan Administrator may change the Benefits described in this SPD and the Member will be

informed of such changes as required by law. This SPD shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Plan Administrator, or by mutual agreement between the Claims Administrator and the Plan Administrator without the consent or concurrence of any Covered Person. By electing medical and Hospital Benefits under the Plan or accepting the Plan Benefits, all Covered Persons legally capable of contracting, and the legal representatives of all Covered Persons incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

Neither the Medical Claims Administrator nor the Plan Sponsor are responsible for the actual care you receive from any person. This SPD does not give anyone any claim, right, or cause of action against the Medical Claims Administrator or the Plan Sponsor based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

The Medical Claims Administrator, on behalf of the Plan Administrator, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

The Medical Claims Administrator has the authority, in its discretion, to institute from time to time, utilization management, care management or disease management in certain designated geographic areas. These pilot initiatives are part of the Medical Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of Benefits which are not provided in the Plan, unless otherwise agreed to by the Plan Sponsor.

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

The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, BCBSHP is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of BCBSHP other than those obligations created under other provisions of the Administrative Services Agreement or this SPD.

Plan Administrator's Sole Discretion

The Plan Administrator may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Plan Administrator, with advice from the Medical Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Medical Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the SPD. This includes, without limitation, the power to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the SPD of the Plan. A specific limitation or Exclusion will override more general benefit language. BCBSHP has complete discretion to interpret the SPD. The Medical Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the twenty-four (24) months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

The Medical Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Plan Administrator 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. The Medical Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Medical Claims Administrator may not give you notice of overpayments made by the Plan or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Member ID Card

If you permit your Member ID 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.

Fraud

Fraud is knowingly and willfully defrauding any health care benefit program by misrepresentation of facts resulting in unauthorized benefits, payments or gains to an individual or entity. Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

If you believe you've found fraud, call our fraud hotline at 800-831-8998. Or, you can call the Blue Cross and Blue Shield of Georgia Member Service number on the back of your member ID card.

Value of Covered Services

For purposes of subrogation, reimbursement of excess Benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount paid for the Covered Services.

Waiver

No agent or other person, except an authorized officer of the Plan Sponsor, is able to disregard any conditions or restrictions contained in this SPD, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The Benefits under this Plan are not designed to duplicate Benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf to the Plan if it has made payment for the services received. It is understood that coverage under this Plan does not replace or affect any Worker's Compensation coverage requirements.

BCBSGa MEDICAL DEFINITIONS

If a word or phrase in this SPD has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Member ID Card.

Accidental Injury

An unexpected injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get Benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed where required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Appeals (Grievance)

An adverse benefit determination that You have the right to appeal. Please see the "Your Right to Appeal" Section.

Assignment of Benefits (AOB)

A method where the person receiving medical benefits assigns the payment of those benefits to a physician or hospital.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that the Medical Claims Administrator has agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, and/or Co-insurance, that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see Section "Claims Payment" for more details.

Benefits

Your right to payment for Covered Services which are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Benefit Period

The length of time that the Plan will cover Benefits for incurred Covered Services. The SHBP is a Calendar Year plan. The Benefit Period starts on January 1st and ends on December 31st.

Benefit Period Maximum

The maximum amount the Plan will pay for specific Covered Services during a Benefit Period.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under

this Plan is not necessarily a COE. To be a COE, the Provider must have a Center of Excellence Agreement with the Medical Claims Administrator.

Co-insurance

Your share of the cost for Covered Services that is a percent of the Maximum Allowed Amount. You normally pay Co-insurance after you meet your Deductible. For example, if your Plan lists 20% Co-insurance on medical service, and the Maximum Allowed Amount is \$100, your Co-insurance would be \$20 after you have met your Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Co-insurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Covered Person

Either the Enrolled Member or an Enrolled Dependent but this term applies only while the person is enrolled under the Plan. References to “you” and “your” throughout this SPD are references to a Covered Person.

Covered Services

Health care services, supplies, or treatment described in this SPD that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this SPD.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigative, excluded, or limited by this SPD, or by any amendment or rider to this SPD.
- Approved by the Medical Claims Administrator before you get the service if Prior Authorization is needed.

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you. The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in the “Termination and Continuation of Coverage” in the separate SPD “2015 Eligibility & Enrollment Provisions Booklet” posted at www.dch.georgia.gov/shbp-summary-plan-descriptions.

Note: Covered Services do not include services or supplies not described in the Provider medical records.

Custodial Care

Any type of care, including room and board, that: (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; and (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers.

Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,

- Catheter care, general colostomy or ileostomy care,
- Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as in a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before Benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan does not pay until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the “Schedule of Benefits” for details.

Dependent

A person who meets all Dependent eligibility requirements as a result of his or her relationship with an Enrolled Member.

Doctor

See definition “Physician.”

Effective Date

The date your coverage begins under this Plan.

Employee

The term Employee means a full-time employee of the State of Georgia, the General Assembly or an agency, board, commission, department, county administration or contracted employer that participates in SHBP.

Enrolled Member

A person who meets all eligibility requirements for the Plan as a result of his or her current or former employment, who is currently enrolled in coverage and who has paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Enrollment Date

The first day you are covered under the Plan or, if the Plan imposes a waiting period, the first day of your waiting period.

Excluded Services (Benefit Exclusion)

Health care services your Plan doesn't cover.

Experimental / Investigational

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

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that

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

Facility

A Facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this SPD. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by the Medical Claims Administrator.

Health Plan or Plan

See definition "State Health Benefit Plan"

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. The provider must be licensed by the appropriate agency.

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 on Accreditation of Health Care Organizations.

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 (ID Card)

The latest Member ID Card given to you will show your identification and group numbers, the type of coverage you have, and the date coverage became effective.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with the Medical Claims Administrator or another organization, to give Covered Services to Members through negotiated payment arrangements.

Inpatient

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

Maximum Allowed Amount

The maximum payment that the Medical Claims Administrator will allow for Covered Services. For more information, see the "Claims Payment" Section.

Medical Claims Administrator

Blue Cross and Blue Shield of Georgia, Inc. is the Medical Claims Administrator and provides administrative claims payment and certain medical management services only.

Medical Necessity (Medically Necessary)

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

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

People, including the Covered Person and his/her Dependents, who have met the eligibility requirements, applied for coverage, enrolled in the Plan, and paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Non-Covered Provider

Providers who are not licensed by law and do not fall into the Provider or Facility Definitions. Examples of Non-Covered Providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Non-Preferred Provider

A Hospital, Freestanding Ambulatory Facility (Surgical Center), Doctor, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have a Point of Service Contract with Contract with the Medical Claims Administrator but is contracted with the Medical Claims Administrator's indemnity network.

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

Out-of-Network Provider

A Provider that does not have an agreement or contract with the Claims, or the Medical Claims Administrator's subcontractor(s), to give Covered Services to Members under this Plan.

You will often get a lower level of Benefits when you use Out-of-Network Providers. For Out-of-Network Providers, the plan does not accept assignment of Benefits. You will receive a payment of Benefits and it will be your responsibility to pay that to the Out-of-Network Provider.

Out-of-Pocket Maximum

The maximum amount, including your yearly deductible and co-insurance, you may have to pay each year with your own money for covered health services. If you reach the out-of-pocket maximum, your eligible expenses are covered 100% by the plan for the remainder of the plan year. The out-of-pocket maximum is higher for out-of-network services.

The most you pay in Deductibles and Co-insurance during a Benefit Period for Covered Services. The Out-of-Pocket Maximum does not include your premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Maximum consists of Deductibles and Co-insurance. See "Schedule of Benefits" for details.

Physician (Medical Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.

Plan

The State Health Benefit Plan

Plan Year

January 1 to December 31

Plan Administrator

The Georgia Department of Community Health, SHBP Division. References to "we", "us", and "our" in

this SPD are to the Department of Community Health, SHBP Division.

Note: The Plan Administrator is not the Medical Claims Administrator.

Plan Sponsor

The Georgia Department of Community Health

Note: The Plan Sponsor is not the Medical Claims Administrator.

Precertification

See Section “Getting Approval for Benefits” for details.

Predetermination

See Section “Getting Approval for Benefits” for details.

Prescription Drug

A medicine 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 the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and are not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Note: Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by BCBSGa. The Prescription Drug Benefits retail, mail order and specialty drug programs are administered by Express Scripts. Refer to the Outpatient Prescription Drug Rider in this SPD.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse Specialist, Physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Prior Authorization

See “Getting Approval for Benefits” Sections for details.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by the Medical Claims Administrator. If you have a question about a Provider not described in this SPD please call the number on the back of your Member ID Card.

Professional Providers include:

- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry;
- Doctor of Dental Medicine (D.D.M.) and Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services, and
- Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Recovery

See “Subrogation and Reimbursement” Section for details.

Referral

See “How Your Plan Works” Section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are commonly staffed by Physician Assistants and nurse practitioners.

Service Area

The geographical area where you can received Covered Services.

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 can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by the Medical Claims Administrator. 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.

Special Enrollment

A period of time in which eligible people or their Dependents can enroll after the initial enrollment, due to a qualifying event such as marriage, birth, adoption, etc. See the separate SPD “Eligibility and Enrollment Provisions Booklet” for more details.

Specialist (Specialty Care Physician / Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

State Health Benefit Plan (SHBP)

The State Health Benefit Plan is comprised of three self-insured plans established by Georgia law: 1) for State employees (O.C.G.A. § 45-18-2), 2) for teachers (O.C.G.A. § 20-2-981), and 3) for non-certified public school employees (O.C.G.A. § 20-2-911). Covered Services are the same under all three self-insured plans and they are usually referred to together as the State Health Benefit Plan.

Summary Plan Description (SPD)

The SPD provides you with a summary description of your SHBP Benefits for Covered Services while you are enrolled under the Plan. The SPD contain a summary description of your Benefits while you are enrolled in the Plan.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

End of Medical Claims Administrator Section

WELLNESS PROGRAM ADMINISTRATOR



Well-Being Program-Be Well SHBP

Well-Being Program Description – Be Well SHBP

State Health Benefit Plan will continue to sponsor Well-Being Programs through a Wellness Program Administrator, Healthways. The Healthways team will provide you with the support, tools and medical information you need to improve your own health and well-being.

Note: The 2015 well-being incentives are not applicable to Kaiser Permanente or the Medicare Advantage Options.

SHBP Web Portal - www.BeWellSHBP.com

The www.BeWellSHBP.com microsite provides a link to Healthways Well-Being Connect portal. Well-Being Connect is a web-based application geared to help eligible Members establish and consistently engage in healthy behaviors through personal Well-Being Plans and helpful tools.

Key components of Well-Being Connect include:

- **Live Chat:** Enables Members to directly outreach to a coach or Member services staff.
- **Well-Being Plan:** The Well-Being Plan helps you reach your healthy best. Your answers to the Healthways Well-Being Assessment[®] (WBA) help gauge the focus areas you're most ready to act on and shape your personal Well-Being Plan.
- **Mobile Application and Smart Phone Technology:** Well-Being Connect mobile app places the power of Well-Being Connect in the hands of smartphone users.
- **Health Trackers:** for medication adherence, exercise, healthy eating, personal tracker (allows Members to create their own tracker), steps program, tobacco cessation, and weight management.
- **Online Campaigns and Challenges:** The Groups and Challenges feature allows Members to interact with one another, or compete against one another in pre-defined challenges for walking (steps program), exercise, and weight loss.
- **Educational Tools and Information:** The portal pushes health information, articles and video segments to Members based on their Well-Being Plan, progress toward behavior change, and specified preferences. There is also a portal library that includes hundreds of articles on health and disease topics, healthy recipes, and meal plans.
- **Device integration to promote fitness, exercise and health and Well-Being:** Members using **Well-Being Connect** can link their own devices, such as a 'Fitbit Ultra' pedometer or 'Withings wi-fi scale,' to the trackers in their personal plans. Once linked, the device will share its data with Well-Being Connect automatically, updating activity trackers. When a participant logs into Well-Being Connect, the data will populate from the device vendor (i.e., Fitbit) and use it to update the appropriate data points in your Well-Being Plan. Neither Healthways nor SHBP can assist with the use of the devices. Members are responsible for making sure that the information is properly tracked.

- **Well-Being Incentive Credits and Rewards Tracking:** The portal supports direct incentive tracking and shows real-time awards accumulation for the Member and spouse if covered. This tracker allows Members to see their incentive progress.

Family Centered Well-Being

The Be Well SHBP program includes an adolescent module entitled, “Health in Motion”. Health in Motion is a self-directed, evidence-based online module that addresses multiple behaviors for preventing obesity through a personalized, science-based, and efficient approach. Log onto www.BeWellSHBP.com and learn more.

Healthways Well-Being Assessment®

The Healthways Well-Being Assessment® (WBA) is a confidential health questionnaire that assesses your lifestyle and overall health. Simply answer a few questions and get instant feedback on what’s helping or hurting your overall health and Well-Being.

The Well-Being report is a personalized summary of overall Well-Being, from your Well-Being Assessment results, that offers insight into actionable steps you can take to improve your health.

Telephonic Well-Being Coaching

Telephonic coaching is designed to help you address identified risks factors and to create a plan to reduce risks and improve your overall health. Areas of risk that coaching can support include: depression prevention, exercise, healthy eating, stress management, tobacco cessation and weight management, as well as other risk areas.

Well-Being Coaches maintain confidentiality and work to establish attainable goals collaboratively with you. Telephonic coaching utilizes many features of the Be Well SHBP portal, including integrating your Well-Being Plan. Your coach will have confidential access to your Well-Being Plan, including your Well-Being Assessment and biometric data, and will be able to see your progress towards your goals. Well-Being Coaching support is provided as long as you need it. Additionally, you can make unlimited in-bound calls for ongoing support as needed.

Individuals identified for coaching will be directly contacted to enroll in the Well-Being Coaching program. Individuals not identified for coaching support may self-enroll by calling 888-616-6411.

Biometric Screenings

A Biometric Screening provides an excellent opportunity to know your numbers and what they mean for you. The screening typically takes 10-15 minutes. During a biometric screening event, a health professional will collect measurements, including body mass index (BMI), blood pressure, cholesterol and glucose. In 2015, SHBP Members and covered spouses will have the opportunity to obtain a biometric screening at their personal Physician’s office or a SHBP sponsored screening event.

2015 Physician Screening Forms

You may complete your screening with your Physician and utilize an easy-to-use 2015 Physician Screening Form. The form can be accessed through the www.BeWellSHBP.com microsite, printed from your computer and taken to your Physician for completion. Each individual will need to log in and enter their first and last name as it appears on their Member ID card, date of birth, zip code and gender to pre-populate the form. Any 2015 Physician Screening Forms not pre-populated will not be processed. The 2015 Physician Screening Form processing oversight is handled by Healthways.

If the 2015 Physician Screening Form submitted by your Physician is incomplete (i.e., missing pre-populated Member information, missing Physician signature or participant signature), your form will not be processed. In order to process your form and have your results loaded into the portal, you will

need to work with your Physician's office to ensure that the form is signed and submitted by the deadline of December 15, 2015. If your form is signed, but only partially completed, your form will be processed as is and the portal will only show results for the data provided.

Well-Being Incentive Credits

In 2015, you and your covered spouse are each eligible to receive a well-being reward of up to 480 well-being incentive credits when you are enrolled in the Blue Cross Blue Shield of Georgia (BCBSGa) HRA Plan Option and complete the activities below between January 15, 2015 and December 15, 2015. That is a family total of 960 well-being incentive credits.

What To Do		What You Earn
1.	<p>ASSESS YOUR HEALTH</p> <p>Complete your 2015 Healthways Well-Being Assessment® (WBA), a confidential, online questionnaire that will take about 20 minutes.</p>	<p>Complete BOTH and earn 240 well-being incentive credits.</p> <p><i>(WBA must be completed before any incentive can be earned)</i></p>
2.	<p>KNOW YOUR NUMBERS</p> <p>Complete a 2015 biometric screening and submit results (body mass index, blood pressure, cholesterol, glucose). The biometric screening must be completed at an SHBP sponsored screening event or by your physician and your results submitted appropriately on the 2015 Physician Screening Form.</p>	
3.	<p>TAKE ACTION</p> <p>It's your choice! Complete the coaching or online pathway, or a combination of both.</p> <p>COACHING PATHWAY</p> <p>Complete your WBA and Actively engage in telephonic coaching.</p> <p>ONLINE PATHWAY</p> <p>Create your WBA and, Record five online well-being activities using the same tracker within four consecutive weeks and earn 40 well-being incentive credits. You can earn these rewards up to six times. A sample online activity would be to track your daily steps five times within four consecutive weeks.</p>	<p>Earn up to 240 well-being incentive credits.</p> <p><i>(WBA must be completed before any incentive can be earned)</i></p>

If you remain in a BCBSGa HRA option (Bronze, Silver, Gold) you will have access to any well-being HRA credits earned in 2014. These HRA credits may be used as long as you are enrolled in a 2015 BCBSGa HRA Plan option, and will roll over in April.

Getting started

To get started log onto www.BeWellSHBP.com and click "Take Your Well-Being Assessment". You will be asked to enter your five registration credentials of First Name, Last Name, Date of Birth, Gender and Zip Code. Your name should be entered exactly as it appears on your Member ID card. Upon registration you will be prompted to take your Well-Being Assessment (WBA).

NOTE: You cannot continue on the site without completing your Well-Being Assessment and creating your Well-Being Plan.

Well-Being Incentive Tracking

Through the Well-Being Connect portal, Members can see up to date statuses regarding well-being incentive credits. The well-being incentive credits will be available the month after completion of the activity. This includes completion of the Well-Being Assessment and biometric screening, enrollment and engagement in Well-Being Coaching, and ongoing participation in the Well-Being Connect portal.

To view your rewards in real-time you must register at www.BeWellSHBP.com. Members have the ability to print their incentive status in the Reward Center of the portal. The Rewards Center also provides Member incentive status and date of award in real-time. Members can perform a print-page function to show evidence they completed the required activities for program completion.

Timelines for Actions to be Posted

The Healthways Well-Being Assessment® will be live on January 15, 2015. Immediately after taking the Well-Being Assessment® you will receive your Well-Being Assessment Report. After January 15, 2015 within 24 hours you will be invited back to the site to register and set up your Well-Being Plan, if you do not already have one. You have until December 15, 2015 to complete your Well-Being Assessment®.

The 2015 action-based incentive credits will be earned as the action is completed and will be available in your incentive account within 31 days. After completion of the Well-Being Assessment, if you complete a Telephonic Well-Being Coaching engagement call and an advising coaching call or if you complete two Telephonic Well-Being Coaching advising calls you will be awarded a total of 240 well-being incentive credits.

When the biometric screening is completed at a 2015 SHBP sponsored screening event or by your Physician in 2015 and the data is successfully completed as outlined within all documents, you will earn 240 well-being incentive credits if you also completed your Well-Being Assessment at www.BeWellSHBP.com.

If your well-being incentive credits are not properly displaying in the www.BeWellSHBP.com Reward Center portal, please call Healthways at 888-616-6411.

Well-Being Incentive Credits Appeals

Appeal Rights under all SHBP Well-Being Plans provided by Healthways, SHBP's Well-Being Program Administrator.

Between February 15, 2015 and January 31, 2016 you and your spouse (if covered) may appeal the total well-being incentive credits applied if the rewards are less than you believe should have been awarded to you or your spouse. Keep proof that you completed the requirements. For example, keep proof of your office visit to a Physician for the biometric screening (if applicable) and a copy of the completed 2015 Physician Screening Form (if applicable). Keep a copy of your completed screening consent form containing results as proof of your onsite screening participation upon completion at a SHBP sponsored event. When you complete the online Well-Being Assessment® through www.BeWellSHBP.com, print a copy of the report. When you complete activities through the Well-Being Coaches or online pathway, print the rewards balance page. You will need to indicate which well-being activity that you are submitting proof for on the 2015 Well-Being Incentive Appeal Form.

2015 Well-Being Incentive Credit Appeal Forms can be found at www.BeWellSHBP.com/appeals/. Please submit the proper form along with the required evidence of completion (which may include a

copy of your screening results from a Physician or SHBP sponsored screening (if applicable), a Well-Being Assessment completion report, and/or a Well-Being Connect reward center screen capture that displays date of completion. Complete 2015 Appeal Forms with attached evidence of completion of the health actions in 2015 will be processed within 30 business days of receipt. You will be notified within 30 business days if your appeal is granted or denied. Your Reward Center Balance on the Healthways Well-Being Connect portal will be updated, if needed. You will be notified in writing if your appeal is approved or denied. If your initial appeal is denied, you will be able to appeal this decision to Healthways by submitting a level two appeal. Your level two appeal must be postmarked within 60 business days following the date of the 2015 Level 1 – appeal decision. This form may also be found at www.BeWellSHBP.com/appeals/.

Please note the 2015 action-based incentives will be earned as the action is completed and will be available in your incentive account within a month of completion. If you think you might be unable to complete the 2015 Well-Being Activities, you might qualify to meet the Well-Being requirements by different means. Contact Healthways at 888-616-6411 and we will work with you (and, if you wish, with your Doctor) to find a Well-Being program with the same reward that is right for you in light of your health status.

Tobacco Cessation

Tobacco Cessation Telephonic Well-Being Coaching

Resources for quitting tobacco that are available to eligible Members, covered spouses and dependents 18 years and older:

- Access to QuitNet® online network to those who have quit or are quitting
- Phone coaching sessions with a trained counselor
- E-mail tips offering motivation and encouragement
- Access to Nicotine Replacement Therapy coverage – see Pharmacy Claims Administrator section
- Tobacco Cessation Well-Being Plans
- Self-refer into coaching or online support via the Well-Being Connect or Quitnet.com at any time.

Individuals identified for tobacco coaching will be directly contacted to enroll in the coaching program. Individuals not identified for coaching support may self-enroll by calling 888-616-6411.

Tobacco Surcharge

Tobacco surcharges are included in all SHBP Options (other than Medicare Advantage Options). These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Telephonic Coaching Program. Please go to www.dch.georgia.gov/shbp-publications-forms to access the tobacco surcharge removal policies and forms. These policies allow you to have the tobacco surcharge removed by completing the tobacco surcharge removal requirements through Healthways.

If you and your enrolled Dependents who use tobacco complete the telephonic or online tobacco cessation Well-Being Coaching program and the well-being assessment, you will be able to avoid the tobacco surcharge for the entire year. This means that any surcharge paid in 2015 may be refunded after the completion of the tobacco surcharge removal requirements. The tobacco surcharge removal requirements must all be completed in 2015. Contact Healthways at 888-616-6411 for more information.

If you think you may be unable to complete the tobacco surcharge removal requirements, you may qualify for an opportunity to avoid the tobacco surcharge by different means. Contact Healthways at 888-616-6411 and we will work with you (and, if you wish, with your doctor) to find a well-being program with the same reward that is right for you in light of your health status.

HEALTHWAY'S DEFINITIONS

Health in Motion

Health in Motion is a self-directed, evidence-based online module that addresses multiple behaviors for preventing obesity through a personalized, science-based, and efficient approach.

Healthways Well-Being Assessment®

The Healthways Well-Being Assessment® (WBA) is a confidential health questionnaire that assesses your lifestyle and overall health. Simply answer a few questions and get instant feedback on what's helping or hurting your overall health and well-being.

Member or Covered Member

People, including the Covered Person and his/her Dependents, who have met the eligibility requirements, applied for coverage, enrolled in the Plan, and paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Physician Screening Form

The Physician Screening Form is a form that your physician can complete with biometric results from your next wellness visit or annual physical exam.

QuitNet®

Healthways, Inc. tobacco cessation program.

QuitNet.com

Healthways tobacco cessation website.

Well-Being Coaching

Well-Being Coaching helps you find opportunities to improve well-being every day. Through convenient phone-based sessions, Well-Being Coaching guides you through healthy behavior changes by building on your strengths. The program is confidential, voluntary, and offered to you as part of your plan benefits at no additional cost to you. You decide if you want to participate and how involved you want to be. All calls are scheduled at your convenience and on your time line. With help from Well-Being Coaching you can:

- Better understand your health risks
- Get answers to your health questions
- Find support to gain more control over your health
- Set goals to reach your healthy best

Well-Being Connect

Well-Being Connect is a web-based application geared to help eligible Members establish and consistently engage in healthy behaviors through personal Well-Being Plans and helpful tools.

Well-Being Plan

Provides tailored feedback and messaging based on the risk factors and behaviors that are contributing to or subtracting from an individual's overall well-being, and is directly integrated in Healthways' Well-Being Connect online application.

Well-Being Report

A personalized summary of overall Well-Being that offers insight into actionable steps you can take to improve your health.

End of the Wellness Program Administrator Section

PHARMACY CLAIMS ADMINISTRATOR



OUTPATIENT PRESCRIPTION DRUG RIDER

This Rider to the Summary Plan Description (SPD) provides Benefits for outpatient Prescription Drug Products. Express Scripts administers your Prescription Drug Pharmacy Benefits.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy, Express Scripts Home Delivery, Accredo (an Express Scripts Specialty pharmacy), or an out-of-network pharmacy.

Because this Rider is part of a legal document, we want to give you information about this document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the Express Scripts Pharmacy Definition Section.

When we use the words “we,” “us” and “our” in this document, we are referring to Department of Community Health (DCH), State Health Benefit Plan (SHBP) Division. When we use the words “you” and “your,” we are referring to people who are Covered Members.

Prescription Drug Product Benefits will be coordinated with those of any other health coverage plan as described in Section “What’s Covered- Prescription Drug Benefits”.

Benefits for Outpatient Prescription Drug Products

This Rider will cover a detailed description about your prescription drug plan benefit supply limits; prior authorizations (PA); maintenance medications; covered medications; non-covered medications; definitions of Generic and Brand-name medications; and the step therapy program.

Benefits are available for outpatient Prescription Drug Products on the Express Scripts prescription drug list, which meet the definition of a covered health service and are dispensed at a licensed pharmacy. Co-insurance (or other payments you are responsible for will vary depending on the outpatient Prescription Drug Product’s placement within the three **(3)** tiers of the Express Scripts Prescription Drug List. See the Prescription Drug Pharmacy Benefits Co-insurance table in the “Schedule of Benefits” Section.

Payment Information

Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the allowed amount. Your Co-insurance is based on which tier the drug falls into and is determined by the Pharmacy Benefit Administrator. Co-insurance amounts will not be overridden or changed on an individual basis.

Note: Your Co-insurance for a Prescription Drug Product at a Network or Out-of-Network Pharmacy (filed with a prescription drug claim form) does not apply to your medical Deductible, Co-insurance, or your Out-of-Pocket Maximum.

For Prescription Drug Products at a participating Retail Network Pharmacy, you are responsible for paying:

- The applicable Co-insurance or
- The applicable Co-insurance and Ancillary Charge or
- The Network Pharmacy Usual and Customary Charge, which includes a dispensing fee and may include sales tax for the Prescription Drug Product if this results in a lower price than the applicable Co-insurance.

For Prescription Drug Products from the Express Scripts Pharmacy Home Delivery Service or Accredo, an Express Scripts Specialty Pharmacy, you are responsible for paying:

- The applicable Co-insurance or
- The applicable Co-insurance and Ancillary Charge
- The Prescription Drug Cost for that Prescription Drug Product if this results in a lower price than the applicable Co-insurance.

Note: For the most up-to-date coverage information (including supply limits, PA requirements, etc.) for Prescription Drug Products that meet the definition of a Covered Health Service, call Express Scripts Member Services number on your Member ID card or at visit Express-Scripts.com/GeorgiaSHBP.

Coverage Policies and Guidelines

Your Express Scripts pharmacy benefit provides coverage for a comprehensive selection of Prescription medications. The most commonly prescribed medications for certain conditions are named or described in the 2015 Express Scripts National Preferred Formulary (Preferred Drug List/PDL). All Covered Outpatient Prescription Drug Products on the PDL are FDA-approved Prescription Drug Products.

The PDL places commonly prescribed medications for certain conditions into tiers.

Your HRA Plan will have Prescription medications placed in tiers.

Prescription medications are categorized within three (3) tiers which are determined by the Pharmacy Administrator. Each tier is assigned a Co-insurance amount which is determined by the Plan. Please consult the Express Scripts National Preferred Drug List at Express-Scripts.com/GeorgiaSHBP, or call the Express Scripts member services number on your Member ID card for the most up-to-date tier status of your medication(s). When you fill a prescription, you pay the Co-insurance at the time the prescription is filled.

Several factors are considered when deciding the placement of a medication on the Express Scripts prescription drug list.

The Express Scripts National Pharmacy and Therapeutics Committee (P&T Committee) evaluates clinical evidence in order to determine a medication's role in therapy and its overall clinical value. In addition, the P&T Committee reviews the relative safety and efficiency of the medication.

The Express Scripts National P&T Committee evaluates the clinical recommendations of the Therapeutic Assessment Committee as well as pharmacoeconomic and economic information provided by the Value Assessment Committee. Once a medication's clinical, pharmacoeconomic and economic value is established, the P&T Committee makes a tier placement decision based on the overall value of the medication. The P&T Committee helps to ensure access to a wide range of affordable medications for you.

Whether a particular Prescription Drug Product is appropriate for an individual Covered Member is a

determination that is made between the Member and their prescribing physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay Co-insurance and other payments, as set forth on the most current Express Scripts prescription drug list. Tier status and Co-insurance will not be overridden or changed.

Member Identification Card (Member ID card) – Network Pharmacy

In order to utilize your Prescription Drug Benefit at a participating Retail Network Pharmacy, you should show your Member ID card at the time you obtain your prescription drug medication at a participating Retail Network Pharmacy.

If you do not show your Member ID card at a Network Pharmacy, you will be required to pay the Full Retail Cost (Usual and Customary Charge) for the Prescription Drug Product at the pharmacy.

If you paid full Retail Cost at the pharmacy and wish to seek reimbursement, you may obtain a prescription drug claim form by calling Express Scripts Member Services on your Member ID card, or on the web at [Express-Scripts.com/GeorgiaSHBP](https://www.express-scripts.com/GeorgiaSHBP). Along with the prescription drug claim form, you will need the pharmacy receipt for your prescription.

You must submit a request for payment of benefits within twelve (12) months following the date of service (also be referred to as the timely filing deadline). If you do not submit this information within the specified time limit, the claim will not be paid.

When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when purchasing the Prescription Drug Product. The amount you are reimbursed will be based on the approved prescription drug cost, less the required Co-insurance and any other applicable charges.

Accredo, an Express Scripts Specialty Pharmacy

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether the drugs are administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. Drugs which have been identified as Specialty Prescription Drugs for your benefit plan are listed on the Express Scripts website: [Express-Scripts.com/GeorgiaSHBP](https://www.express-scripts.com/GeorgiaSHBP). Your prescriptions must be filled through Accredo's home delivery program if you have a prescription for one of these products. See "Glossary and Definitions" for definitions of Specialty Prescription Drug Product and Designated Pharmacy. See "What's Covered-Prescription Drug Benefits" Section for more information on Specialty Prescription Drug Product.

Note: If you use any pharmacy other than Accredo **after the first fill, you'll be subject to the entire cost of the medication.**

Limitation on Selection of Pharmacies

If Express Scripts determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, Express Scripts may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within thirty-one (31) days of the date we notify you, Express Scripts will select a single Network Pharmacy for you.

Member Rights and Responsibilities

As a member, you have the right to express concerns about your SHBP coverage and to expect an unbiased resolution of your individual issues. You have the right to submit a written appeal or inquiry regarding any concern that you may have about the prescription drug program or your drug coverage.

Express Scripts Member Services

Written appeals and inquiries related to the prescription drug program should be directed to:

Express Scripts Appeals Department
State of Georgia Health Benefit Plan Members
P.O. Box 66588
St. Louis, MO 63166-6588

Prescription Drug Disclaimer

This SPD summarizes the State Health Benefit Plan Prescription Drug Program. It is not intended to cover all details related to your prescription drug coverage under the SHBP. This SPD is not a contract and the Benefits that are described can be terminated or amended by the Plan Administrator according to applicable laws, rules and regulations. If there are discrepancies between the information in this booklet and DCH Board regulations or the laws of the state of Georgia, or the Board resolutions setting required contributions, those regulations, laws and resolutions will govern at all times.

WHAT IS COVERED - PRESCRIPTION DRUG BENEFITS

Express Scripts will provide Pharmacy Benefits under the plan for outpatient Prescription Drug Products:

- Designated as covered at the time the prescription is dispensed when obtained from a Network Pharmacy (Retail, Home Delivery or Specialty Designated Pharmacy), or when a paper claim is filed and the prescription was designated as covered at the time it was dispensed.
- Refer to exclusions in this Section "What' is Not Covered: Prescription Drug Exclusions".

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service.

Benefits for outpatient Prescription Drug Products are available through three types of Network pharmacies: Retail Network Pharmacies; the Express Scripts PharmacySM Home Delivery Service; and Accredo, an Express Scripts Specialty Pharmacy.

You can obtain information about participating Retail Network Pharmacies by calling the toll-free number on the back of your Member ID card, or on the web at Express-Scripts.com/GeorgiaSHBP.

Covered Members that enroll in Disease Management for Diabetes, Coronary Artery Disease (CAD) and Asthma may qualify for the Disease Management (DM) Pharmacy Co-insurance Waiver Program, which allows you to get select medications for these disease states at zero Co-insurance. If you have Diabetes, Asthma and/or CAD and are interested in participating in the Personal Health Coach Program and learning more about how to qualify for the Co-insurance waiver incentive, please call BCBSGa Member Services toll-free at 855-641-4862.

When a Brand-name Drug Becomes Available as a Generic

When a Brand-name drug becomes available as a Generic Prescription Drug Product, the cost of the Brand-name Prescription Drug Product may change, and therefore your Co-insurance may change. You will pay the applicable Co-insurance for the Prescription Drug Product. If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Generic Prescription Drug Product (Generic equivalent), you will pay the applicable Generic Co-insurance amount as well as the difference in cost between the Brand and Generic Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. With the required Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. You may determine if a Prescription drug has been assigned a supply limit for dispensing call the Express Scripts member services number on the back of your Member ID card or on the web at Express-Scripts.com/GeorgiaSHBP.

Note: Some products are subject to additional supply limits based on criteria that Express Scripts has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

Network Pharmacy Notification (Prior Authorization) or Coverage Review Requirements

When Prescription Drug Products are dispensed at a Network Pharmacy and require notification (also known as Prior Authorization), the prescribing Provider, the Pharmacist or you are responsible for notifying Express Scripts for approval. If Express Scripts is not notified for approval before the

Prescription Drug Product is dispensed at a participating Network Pharmacy then the prescription is not eligible for coverage and you will be required to pay the Full Retail Cost (Usual and Customary Charge) for that prescription at the pharmacy. If Express Scripts is notified within twelve (12) months after the date the prescription was filled and the Notification is retroactively approved then you may request reimbursement from Express Scripts. The Prescription Drug Products requiring Notification are subject to periodic review and modification. You may find out whether a particular Prescription Drug Product requires Notification by consulting your Prescription Drug List through [Express-Scripts.com/GeorgiaSHBP](https://www.express-scripts.com/GeorgiaSHBP) or by calling Express Scripts Member Services at the number on your Member ID card.

Note: Notification approval will be required before the claim will be considered for reimbursement. If Express Scripts is notified within 12 months after you pay the Full Retail Cost and the Notification is denied, you will not be reimbursed.

Out-of-Network Pharmacy Notification or If You Do Not Present Your Member ID card

If a prescription is filled by an out-of-network pharmacy or without use of your Member ID card you can submit that claim for reimbursement up to twelve (12) months after the date the prescription was filled. If the drug required notification approval and that was not obtained prior to filling the prescription then it can be requested at the time the claim is submitted. If the notification is not approved, then you will not be able to be reimbursed for your claim.

When you submit a claim on this basis, you may pay more because you did not notify Express Scripts before the Prescription Drug Product was dispensed and because the out-of-network pharmacy you used is not bound by the network pricing under our plan. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Co-insurance and Ancillary Charge, if applicable.

If you wish to seek reimbursement, you may obtain a prescription drug claim form from Express Scripts by calling the Express Scripts Member Services number on your Member ID card, or log into [Express-Scripts.com/GeorgiaSHBP](https://www.express-scripts.com/GeorgiaSHBP). Along with the prescription drug claim form, you will need a pharmacy receipt for your prescription and if applicable- an explanation of benefits (EOB) from your primary carrier.

Requesting Reimbursement for a claim you paid Full Retail Cost

When you use an Out-of-Network Pharmacy, or if you do not show your Member ID card or provide verifiable information at a Network Pharmacy, you must pay the Full Retail Cost (Usual and Customary Charge) for your prescription and then submit a prescription drug claim form to Express Scripts for reimbursement of covered drug costs as has been described above. Assignment of Benefits (AOB) is not available.

The prescription drug claim form must be filled out in its entirety and mailed to the address on this form. Any missing information may cause a delay in processing your reimbursement. Required information includes the pharmacy seven-digit NCPDP number (this number should be identified on your pharmacy receipt), the National Drug Code (NDC) number for your prescription (this can be obtained from your pharmacy), the prescription number, the name of the pharmacy, the physician's name, the member ID number, and the patient's name and date of birth. A pharmacy receipt and an EOB from your primary carrier (if applicable) will also be required along with the claim form.

You will be reimbursed the approved Prescription Drug Cost less the applicable Co-insurance. Also, you are subject to Benefit plan rules (including but not limited to notification and step therapy) as well as balance billing if the charged amount exceeds the network cost of your prescription(s).

Step Therapy Program Requirements

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products, for which Benefits are described in your Summary Plan Description (SPD), are subject to Step Therapy Program requirements (also known as Step Therapy). This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products, you are required to use (a) different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to Step Therapy requirements through Express-Scripts.com/GeorgiaSHBP or by calling the Express Scripts Member Services number on your Member ID card.

Clinical Appeal Process

If a notification or quantity limitation request is denied by Express Scripts, you or your physician may initiate the clinical appeals process.

Express Scripts recommends that a physician initiate an appeal for a denied notification decision by Express Scripts so that all necessary clinical information can be obtained.

The request/appeal must be submitted in writing (via letter) to Express Scripts for consideration. The appeal must be submitted within 180 calendar days of the date of the denial letter. This is known as the first-level appeal. The written inquiry should be directed to:

Express Scripts Appeals Department
State of Georgia Health Benefit Plan Members
P.O. Box 66588
St. Louis, MO 63166-6588

Express Scripts will advise you in writing of its decision. If Express Scripts upholds the denial, information regarding the second-level appeal process will be provided to you.

Second-level appeals (an appeal to the first-level appeal decision described above) must be initiated by you or your authorized representative and must be received in writing (via letter). Express Scripts recommends that a Physician initiate an appeal for a denied first-level appeal decision by Express Scripts so that all necessary clinical information can be obtained. The second-level appeal must be submitted within 60 calendar days of the date of the first-level appeal denial letter.

The second-level appeal request, along with any new and/or additional supporting documentation, shall be forwarded to Express Scripts to the address above. The second-level appeal decision is the final decision under the plan.

If, after exhausting the two levels of appeal available to you under your plan, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons; or
- the exclusions for experimental, investigational or unproven services.

The external review program is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits. Contact Express Scripts at the toll-free number on your Member ID card for more information.

Preventive Care Medications

Preventive Care Medications and over-the-counter (OTC) medications are covered as described in

the “Prescription Drug Glossary and Definition” in this Section of the SPD. For these Preventive Care Medications to be covered, you must obtain a prescription from your Doctor and meet the age/gender or other requirements. As part of the Patient Protection and Affordable Care Act, certain contraceptive Prescription Drug Products are covered as Preventive Care Medications at no cost to the Member.

You may determine whether a drug is a Preventive Care Medication through [Express-Scripts.com/GeorgiaSHBP](https://www.express-scripts.com/GeorgiaSHBP) or by calling the Express Scripts Member Services on your Member ID card. You may not be responsible for paying Co-insurance for these Preventive Care Medications.

Tobacco Cessation Medications

A 90-day treatment cycle of OTC or prescription tobacco cessation medications is available through a Retail Network Pharmacy at no cost to the member. The 90 day treatment cycle will be dispensed as a 31-day supply with 2 refills allowed. A prescription is required for coverage.

A total of two (2) 90-day treatment cycles are allowed per year at no cost to the member.

The Tobacco Cessation Telephonic Coaching program is available to Covered Members age 18 and older to assist them to become tobacco-free. Please see the Tobacco Cessation Incentive Program in the Wellness Administrator section of this SPD. To enroll in the Tobacco Cessation Incentive Program, please call Healthways at 888-616-6411.

Coordination of Benefits (COB)

If your spouse or a dependent has primary coverage from another health plan, or if you or your spouse as a retiree have a Medicare Part D plan, prescription drug benefits provided by the SHBP will be coordinated with the other insurance carrier(s). This means you must first use your primary insurance plan when you pay for your prescription(s).

To request a secondary payment from Express Scripts at the time of purchase, you can request the pharmacist to electronically file SHBP secondary (see below).

Coordination of Pharmacy Benefits between your Medicare Part D plan and SHBP

- If you have a Medicare Part D plan as primary, each time you go to the pharmacy, present both your Medicare Part D and SHBP identification cards.
- When Medicare COB occurs, you should not be responsible for more than your SHBP Co-insurance for eligible charges.
- When you reach the Medicare Part D coverage gap, you should still present both identification cards and you will pay your SHBP Co-insurance.

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as notification and step therapy, receive approval before your claims may be considered for reimbursement.

Coordination of Pharmacy Benefits between your Primary Prescription Drug Plan (PDP) and SHBP

- If you have another health plan as primary, each time you go to the pharmacy, present both your primary insurance carrier and SHBP Member ID cards.
- When COB occurs, you should not be responsible for more than your SHBP Co-insurance for eligible charges.

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as Notification and Step Therapy, receive approval before your claims may be considered

for reimbursement.

To request a secondary payment from Express Scripts after the time of purchase, you can send a prescription drug claim form and attach a copy of the EOB from the primary plan and the pharmacy receipt. You can obtain a copy of the prescription drug claim form by calling the Express Scripts member services number on your Member ID card, or through [Express-Scripts.com/GeorgiaSHBP](https://www.express-scripts.com/georgia-shbp).

When the SHBP is the secondary plan, benefits are coordinated to pay only the difference between the amount paid by the primary plan and the allowable amount payable by the SHBP.

Note: The amount paid as secondary payor will not exceed the allowable amount payable by the SHBP. Please call the Express Scripts member services number on your SHBP Member ID card for more details. If you have coverage under two SHBP contracts (cross-coverage or dual coverage), Prescription Drug Benefits provided by the SHBP will not be coordinated. Co-insurance will be required for each filled prescription. If you have coverage under a Medicare Advantage plan, benefits provided by the SHBP pharmacy benefits will not be coordinated.

PHARMACY TYPE AND SUPPLY LIMITS

Prescription Drugs from a Participating Retail Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a participating Retail Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the applicable Co-insurance for each cycle supplied based on the type of pharmacy used (standard retail pharmacy or 90-day network pharmacy).

Note: For covered Prescription Drug Products dispensed from an Out-of-Network Pharmacy, the same rules apply for reimbursement.

If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Generic Co-insurance in addition to the difference between the Brand and Generic Drug costs.

Note: Pharmacy benefits apply only if your prescription is for a Covered Health Service, and not for experimental, investigational or unproven services. Otherwise, you are responsible for paying 100% of the cost.

Your Co-insurance is determined by the tier to which the Express Scripts Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the PDL are assigned to Tier 1, Tier 2 or Tier 3. Please consult your PDL, view at [Express-Scripts.com/GeorgiaSHBP](https://www.ExpressScripts.com/GeorgiaSHBP), or call the Express Scripts Member Services number on your Member ID card to determine tier status.

Note: Prescription Co-insurance does not apply to the Deductible or the Member's Out-of-Pocket Maximum. Co-insurance payments will not be overridden or changed on an individual basis.

Coverage for up to a 31-day supply for a participating Retail Network Pharmacy:

Tier 1: 15% Min \$20, Max \$50

Tier 2: 25% Min \$50, Max \$80

Tier 3: 25% Min \$80, Max \$125

Coverage for up to 31-day supply from a Retail Non-Network Pharmacy

In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Pharmacy. If the out of network pharmacy you use bills more than the plan would reimburse for that same drug to a network pharmacy under their contracted rates then you must pay the difference in cost plus your Co-insurance as outlined below.

The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Co-insurance for each cycle supplied.

Coverage for up to a 31-day supply for a non-participating Retail Pharmacy:

Tier 1: 15% Min \$20, Max \$50

Tier 2: 25% Min \$50, Max \$80

Tier 3: 25% Min \$80, Max \$125

Specialty Prescription Drug Products from Accredo, an Express Scripts Specialty Pharmacy

For Benefits provided for outpatient Specialty Prescription Drug Products dispensed by Accredo, an Express Scripts Specialty Pharmacy, the following apply:

- As written by a Physician up to a 31 day supply; or
- Up to a 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits
- When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a 31-day supply, the Co-insurance that applies will reflect the number of days dispensed.

You must use Accredo to receive coverage for Specialty Prescription Drug Products. Initially, you may obtain one fill of your Specialty Prescription Drug Product from a participating Retail Network Pharmacy. Thereafter, you will be required to use Accredo to continue coverage for your Specialty Prescription Drug Product. If you do not use Accredo, the Specialty Prescription Drug Product is not eligible for coverage and you will be required to pay the Full Retail Cost for that prescription at the retail pharmacy.

Specialty Coverage for up to a 31-day supply from Accredo:

- Tier 1:** 15% Min \$20, Max \$50
- Tier 2:** 25% Min \$50, Max \$80
- Tier 3:** 25% Min \$80, Max \$125

Prescription Drug Products from Express Scripts Home Delivery

The following supply limits apply for Benefits for outpatient Prescription Drug Products dispensed by the Express Scripts Pharmacy Home Delivery Service:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- Your doctor must write your prescription for a 90-day or 3-month supply with refills when appropriate (not a 1-month supply with three refills).

Note: You will be charged a 90-day Home Delivery Service Co-insurance regardless of the days' supply actually dispensed.

To fill the prescription, you may:

- Mail your prescription(s) along with the required form in the envelope provided with your Welcome Package.
- Ask your Doctor to call 888-327-9791 for instructions on how to fax the prescription. Your Doctor must include your Member ID number.
- Order through the Express Scripts website after registering at [Express-Scripts.com/GeorgiaSHBP](https://www.express-scripts.com/GeorgiaSHBP).

Note: If you submit a prescription for a 1-month supply to the Express Scripts Pharmacy Home Delivery service, it will be filled but you will be charged the 90-day Co-insurance amount, so make sure you submit only maintenance prescriptions that you take on a regular basis for a full 90-day supply from Home Delivery.

Coverage up to a consecutive 90-day supply through Home Delivery:

- Tier 1:** 2 ½ x the monthly Co-insurance for up to a 90-day supply 15% Min \$50, Max \$125
- Tier 2:** 2 ½ x the monthly Co-insurance for up to a 90-day supply 25% Min \$125, Max \$200
- Tier 3:** 2 ½ x the monthly Co-insurance for up to a 90-day supply 25% Min \$200, Max \$313

Express Scripts offers two ways to obtain up to a 90-day supply of maintenance drugs.

1. Some participating retail pharmacies in our Network allow you to get up to a 90-day supply of maintenance drugs at the home delivery Co-insurance rates. These are called 90-day retail network pharmacies. To determine which participating retail pharmacies pass through the discounted Co-insurance rates for a 90-day supply, visit [Express-Scripts.com/GeorgiaSHBP](https://www.express-scripts.com/GeorgiaSHBP) and click "Locate a pharmacy." Any participating 90-day retail pharmacy will have the following statement after the address: "Dispenses a maintenance supply: YES". You can also locate participating retail pharmacies on the Express Scripts mobile app or call Express Scripts at the number on the back of your Member ID Card.
2. You can use the Express Scripts Pharmacy Home Delivery Service.

WHAT IS NOT COVERED – PRESCRIPTION DRUG EXCLUSIONS

Exclusions from coverage listed in the SPD apply also to this Rider. In addition, the following prescription drug exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) that exceeds the supply limit.
2. Drugs that are prescribed dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility or Alternate Facility.
3. Experimental, Investigational or Unproven Services and medications; medications and/or indications not approved by the Food and Drug Administration (FDA) used for experimental indications and/or dosage regimens determined by Express Scripts to be experimental, investigational or unproven.
4. Prescription Drug Products furnished by the local, state or Federal government. Any Prescription Drug Product to the extent payment or Benefits are provided or available from the local, state or Federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
5. Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.
6. Any product dispensed for the purpose of appetite suppression and other weight loss products.
7. An injectable Prescription Drug Product (including, but not limited to, immunizations and allergy serum) that, due to its characteristics as determined by Express Scripts, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to flu, Gardasil, Ceravix and Zostavax vaccines self-administered injectable medications and Specialty medications covered through your Pharmacy Benefit plan.
8. The cost of labor and additional charges for compounding prescriptions, excluding contractual dispensing fees that Pharmacies charge.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins except the following, which require a prescription: prenatal vitamins, vitamins with fluoride and single-entity vitamins.
11. Medications used for cosmetic purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
13. Prescription Drug Products when prescribed to treat infertility.
14. Compounded drugs that do not contain at least one covered ingredient that requires a prescription. Other coverage rules may apply.
15. Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed except for certain preventive OTC drugs – aspirin, fluoride, folic acid and Iron – that require a prescription for coverage.
16. Yohimbine.
17. Mifeprex.
18. Blood or blood plasma products except for hemophilia factors.
19. Growth hormone used for the treatment of short stature in the absence of identified sickness or injury.

20. Specialty Prescription Drugs purchased at a pharmacy that is not a Specialty Designated Pharmacy (except for the first prescription fill or in some limited cases two prescription fills of the Specialty Prescription Drug, which may be purchased from a Retail Pharmacy).
21. Nutritional supplements, except for those specifically identified as included under the plan. Contact Express Scripts Member Services for a list of covered supplements.
22. Any Prescription Drug Product that is therapeutically equivalent to an OTC drug. Prescription Drug Products that compromise components that are available in OTC form or an equivalent.

FREQUENTLY ASKED QUESTIONS- PRESCRIPTION DRUG

This section will help you understand your medication choices and make informed decisions, plus it will help you understand which questions to ask your Doctor or Pharmacist.

What is a Prescription Drug List (PDL)?

A PDL is a list of FDA-approved Brand-name and Generic medications. The PDL is one way you can find out the tier status and specific rules linked to your medication. The PDL lists the most commonly prescribed medications for certain conditions.

The PDL offers a wide choice of Brand-name and Generic medications that are reviewed by Doctors and Pharmacists on the Express Scripts National Pharmacy and Therapeutics Committee. The list is updated to reflect decisions based on new medical evidence and information. Additionally, the FDA approves all medications, including Generics, which means you can be confident that whatever medication you choose, it meets the strict guidelines set by the FDA.

Your Express Scripts Pharmacy Benefit provides coverage for a comprehensive selection of prescription medications. You can check which medications are on which tiers at ExpressScripts.com/GeorgiaSHBP. You and your physician can refer to this list to consider prescription medication choices and select the appropriate medication to meet your needs.

Understanding Tiers

Prescription medications are categorized within three tiers which are determined by the Pharmacy Administrator. Each tier is assigned a Co-insurance. Consult your Benefit plan documents to find out the specific Co-insurance that are part of your plan. You and your Doctor decide which medication is appropriate for you.

Tier 1: Your Lowest-Cost Option

- Tier 1 medications are your lowest Co-insurance option. For the lowest out-of-pocket expense, always consider Tier 1 medications if you and your doctor decide they are right for your treatment.

Tier 2: Your Midrange-Cost Option

- Tier 2 medications are your middle Co-insurance option.

Tier 3: Your Highest-Cost Option

- Tier 3 medications are your highest Co-insurance option. If you are currently taking a medication in Tier 3, ask your Doctor whether there are lower-cost Tier 1 or Tier 2 medications that may be right for your treatment.

Note: Compounded medications are medications with two or more ingredients that are prepared “on-site” by a Pharmacist. These are classified at the Tier 3 level.

What factors are looked at when making tier placement decisions, and who decides which medications get placed in which tier?

Several factors are considered when deciding the placement of a medication on the Prescription Drug List, including the medication’s classification. Several committees contribute and evaluate the overall value of the medication to ensure an unbiased approach. Committee members are various health care professionals, including Pharmacists and Physicians with a broad range of specialties.

The two main committees are:

- **The Express Scripts National Pharmacy and Therapeutics (P&T) Committee**, which evaluates clinical evidence in order to determine a medication’s role in therapy and its overall clinical value. In addition, the P&T Committee reviews the relative safety and efficacy of the medication.

- **Express Scripts**, which evaluates the clinical recommendations of the P&T Committee as well as pharmacoeconomic and economic information. Once a medication's clinical, pharmacoeconomic and economic value is established, Express Scripts' Value Assessment Committee makes a tier placement decision based on the overall value of the medication. The Value Assessment Committee helps to ensure access to a wide range of affordable medications for you.

How often will Prescription medications change tiers?

Most tier changes will occur on January 1 and July 1. Medications may move to a lower or higher tier. Additionally, when a Brand-name medication becomes available as a Generic, the tier status of the Brand-name medication and its corresponding Generic will be evaluated. When a medication changes tiers, you may be required to pay more or less for that medication. Express Scripts will notify members 60 days in advance for formulary changes that result in a drug moving to a higher cost tier. For the most current information on your pharmacy coverage, please call Express Scripts Member Services on your Member ID card or [log on to Express-Scripts.com/GeorgiaSHBP](http://log.on.to/Express-Scripts.com/GeorgiaSHBP).

What is the difference between Brand-name and Generic medications?

Generic medications contain the same active ingredients as Brand-name medications, but they often cost less. Generic medications become available after the patent on the Brand-name medication expires. At that time, other companies are permitted to manufacture an FDA-approved, chemically equivalent medication. Many companies that make Brand-name medications also produce and market Generic medications.

The next time your Doctor gives you a prescription for a Brand-name medication, ask if a Generic equivalent is available and if it might be appropriate for you. While there are exceptions, Generic medications are usually your lowest in cost. Go to Express-Scripts.com/GeorgiaSHBP to determine if an equivalent Generic medication is available.

Why is the medication that I am currently taking no longer covered?

Medications may be excluded from coverage under your Pharmacy Benefit. For example, a Prescription medication may be excluded from coverage when it is therapeutically equivalent to an over-the-counter (OTC) medication. For possible coverage alternatives, please call the Member Service number on your Member ID card.

When should I consider discussing Over-the-Counter or Non-Prescription medications with my doctor?

An OTC medication can be an appropriate treatment for many conditions. Consult your doctor about OTC alternatives to treat your condition. These medications are not covered under your Pharmacy Benefit (except certain Preventive Care medications), but they may cost less than your out-of-pocket expense for Prescription medications.

What is a maintenance medication program?

Maintenance Prescription Drug Products are long-term medications taken to treat an ongoing condition, such as high blood pressure, high cholesterol or diabetes. Maintenance medications are those prescribed medications that a member may obtain for a period of up to 90 days per fill.

You may obtain up to a 90-day supply if your Physician writes a prescription for a 90-day supply. For example, if you take two tablets a day, your Physician must write a prescription for a quantity of 180 tablets to be dispensed.

Please log into Express-Scripts.com/GeorgiaSHBP or call the Express Scripts Member Services number if you have specific questions regarding whether a medication is covered as a maintenance medication. Certain medications have been categorized as maintenance medications.

Which maintenance medications are included in the maintenance medication program?

Maintenance medications include but are not limited to:

- Anti-Parkinson medications
- Asthma medications that are taken orally, excluding inhalers
- Cardiovascular medications for hypertension and heart disease
- Diabetic medications
- Estrogen and progestin medication
- Medications for the treatment of epilepsy
- Oral contraceptives
- Thyroid medications

Please call the Express Scripts Member Services number on the back of your Member ID card if you have specific questions regarding whether a medication is covered as a maintenance medication.

What are the supply limits (SL) programs?

The SL program defines the maximum quantity that can be dispensed per Co-insurance (Quantity Level Limit, or QLL) or specified time frame (Quantity Duration, or QD). Supply limits are based upon the manufacturer's package size, dosing recommendations or guidelines that are included in the FDA labeling, and medical literature and guidelines.

How do the SL programs work?

If your prescription exceeds the supply limit, your pharmacist will be notified of the quantity covered for your Co-insurance.

You will have the following options:

- Accept the established quantity limit
- Pay additional out-of-pocket costs that exceed the quantity limits (as appropriate)
- Discuss alternatives with your Doctor before deciding whether to fill the prescription
- Request Coverage Authorization Review for the additional amounts through the Coverage Review process (when available)

What is a Coverage Review, Notification, or Prior Authorization?

A Coverage Review, Notification, or Prior Authorization (PA) is a set of clinical rules designed to support the Pharmacy Benefit at the time the prescription is dispensed. Applied to a limited number of medications, Notification requires your Doctor to provide additional information to determine whether the use of the medication is covered by your Pharmacy Benefit and to ensure appropriate use.

How does the program work?

If your medication is included in a Notification program, your pharmacy is sent a message on the computer system with instructions to have your Doctor call a toll-free number to get approval for the prescription. Some Pharmacists will contact your doctor while others may request you do so. Your Doctor will provide Express Scripts with information to determine if the prescription meets the coverage conditions of your Pharmacy Benefit. Express Scripts will review the information and approve or deny coverage. Express Scripts will send letters to you and your Doctor explaining the decision and providing instructions on how to appeal if you so desire.

What should I do if I use a self-administered injectable medication?

You may have coverage for self-administered injectable medications through your Pharmacy Benefit plan or under your Medical Benefits.

Please call Express Scripts Member Services number on your Member ID card to determine whether

a medication is covered as a self-administered injectable under your Pharmacy or Medical Benefits.

How do I obtain a supply of my medications before I go on vacation?

You may receive up to a 3 month supply of medication from the Express Scripts Home Delivery Service as long as it is indicated on your prescription. If you are going to run out of medication while you are on vacation, you may receive an early 3-month supply up to two times per year. You will be responsible for the Co-insurance associated with that supply. There are some limitations with controlled or temperature-sensitive medications. For more information, call the Express Scripts Member Services number on your Member ID card.

If you would like to obtain a supply of medication prior to leaving for your vacation, you will need to inform your local Network Pharmacist. Your Pharmacist should know how to process your vacation request, however if not please have your Pharmacist contact the Express Scripts Pharmacy help desk at 800-922-1557.

You may also locate a Network Pharmacy at your vacation destination by calling the Member Service number on your Member ID card, or log into Express-Scripts.com/GeorgiaSHBP.

How do I access updated information about my Pharmacy Benefit?

Call the Express Scripts Member Services number on your Member ID card for more current information. Or log into Express-Scripts.com/GeorgiaSHBP for the following pharmacy resources and tools:

- Pharmacy Benefit and coverage information
- Specific Co-insurance amounts for Prescription medications
- Possible lower-cost medication alternatives
- A list of medications based on a specific medical condition
- Medication interactions and side effects, etc.
- Locate a participating Retail Pharmacy by ZIP code
- Review your prescription history

What if I still have questions?

Please call the Express Scripts Member Services number on your Member ID card. Representatives are available to assist you 24 hours a day.

PRESCRIPTION DRUG GLOSSARY AND DEFINITIONS

This section defines the terms used throughout this Outpatient Prescription Drug Rider.

Ancillary Charge: A charge that, in addition to the Co-insurance, you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent generic Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the approved Prescription Drug Cost for Network Pharmacies for the Brand-name Prescription Drug Product, and the approved Prescription Drug Cost of the chemically equivalent Prescription Drug Product available.

Brand-name: A Prescription Drug Product that: (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) Express Scripts identifies as a Brand-name product based on available data resources – including, but not limited to, First DataBank– that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as “Brand-name” by the manufacturer, Pharmacy or your Physician may not be classified as Brand-name by Express Scripts.

Covered Person: Either the Enrolled Member or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to “you” and “your” throughout this chapter are references to a Covered Person.

Co-Insurance: A percentage of the total cost of the claim that must be paid by the Member.

Designated Pharmacy: A pharmacy that has entered into an agreement on behalf of the pharmacy with Express Scripts, or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Full Retail Cost: Also known as Usual and Customary Charges. This is the amount that a Pharmacist would charge a cash-paying customer for a prescription.

Generic: A Prescription Drug Product that: (1) is chemically equivalent to a Brand-name drug; or (2) Express Scripts identifies as a Generic product based on available data resources – including, but not limited to, First DataBank – that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as a “Generic” by the manufacturer, pharmacy or your Physician may not be classified as a Generic by Express Scripts.

Home Delivery Service: Allows members requiring maintenance medications the convenience of having maintenance medications delivered to the home or office by the plan's Home Delivery pharmacy service (a pharmacy whose primary business is to dispense Prescription drugs or devices under Prescription drug orders and to deliver the drugs or devices, usually to patients' homes, by US mail, a common carrier or a delivery service).

Member or Covered Member: People, including the Covered Person and his/her Dependents, who have met the eligibility requirements, applied for coverage, enrolled in the Plan, and paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Network Pharmacy: A pharmacy that has:

- Entered into an agreement with Express Scripts or its designee to provide Prescription Drug Products to Covered Persons
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products
- Been designated by Express Scripts as a Network Pharmacy

A Network Pharmacy can be a participating Retail, Home Delivery or Specialty Designated Pharmacy.

New Prescription Drug Product: A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug

Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by the Plan's Pharmacy Administrator's Prescription Drug List Management Committee, or
- December 31st of the following plan year

Prescription Drug Cost: The rate Express Scripts has contracted with the Network Pharmacies on behalf of SHBP, including a dispensing fee and any sales tax, if applicable, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug Product: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a prescription. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver or a skilled caregiver in the case of certain Specialty medications. For the purpose of Benefits under the plan, this definition includes:

- Inhalers (with spacers)
- Insulin

The following diabetic supplies:

- Insulin syringes with or without needles
- Urine/Blood Test Strips & Tapes
- Lancets
- Blood Glucose Testing monitors
- Continuous Glucose Monitor/Transmitters/Sensors

Preventive Care Medications: The medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-insurance) as required by applicable law under any of the following:

- with respect to infants, children and adolescents, evidence-informed preventive care provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

You may determine whether a drug is a Preventive Care Medication at Express-Scripts.com/GeorgiaSHBP or by calling Express Scripts at the toll-free telephone number on your Member ID card.

Specialty Designated Pharmacy: A Specialty Pharmacy that has entered into an agreement on behalf of the pharmacy with Express Scripts or with an organization contracting on its behalf, to provide specific Specialty Prescription Drug Products.

Specialty Prescription Drug Product: A Prescription Drug Product that is generally a high-cost, oral or self-injectable biotechnology drug used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drugs at www.express-scripts.com/GeorgiaSHBP or by calling the number on the back of your Member ID card.

Usual and Customary Charge: The amount that a Pharmacist would charge a cash-paying customer for a prescription.

End of Pharmacy Claims Administrator

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician/Provider (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network, and who is available to accept you or your family members. For children, you may also designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of participating PCP's, call the telephone number on the back of your Identification Card.

Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on the back of your Identification Card.

HIPAA Special Enrollment Notice

If you decline enrollment for yourself, or your Dependents (including your spouse) because of other health insurance coverage, you will be able to enroll yourself and your Dependents if your other health insurance coverage ends. However, you must request enrollment within 31 days after your other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly eligible dependent child).

Eligible Covered Persons and Dependents may also enroll under two additional circumstances:

- The Covered Person's, Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Covered Person or Dependent becomes eligible for a subsidy (State Premium Assistance Program).

NOTE: The Covered Person or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination. To request Special Enrollment or obtain more information, call the Customer Service telephone number on the back of your Identification Card, or contact your Benefit Coordinator/Payroll Location.

Women's Health and Cancer Rights Act of 1998

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option. Following cancer surgery, the SHBP covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance

- Prostheses and mastectomy bras
- Treatment of physical complications of mastectomy, including lymphedema

NOTE: Reconstructive surgery requires prior approval, and all Inpatient admissions require prior notification.

For more detailed information on the mastectomy-related benefits available under the Plan, call the telephone number on the back of your Identification Card.

Newborns' and Mothers' Health Protection Act of 1996

The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.

Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit 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, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF INFORMATION PRIVACY PRACTICES

Georgia Department of Community Health

State Health Benefit Plan Notice of Information Privacy Practices

Revised September 25, 2014

The purpose of this notice is to describe how medical information about you, which includes your personal information, may be used and disclosed and how you can get access to this information. Please review it carefully.

The Georgia Department of Community Health (DCH) and the State Health Benefit Plan Are Committed to Your Privacy. DCH is the Plan Sponsor and administers the health plan through the State Health Benefit Plan (the Plan). DCH understands that your information is personal and private. Certain DCH employees and companies hired by DCH to help administer the Plan (Plan Representatives) use and share your personal and private information in order to administer the Plan. This information is called "Protected Health Information" (PHI), and includes any information that identifies you or information in which there is a reasonable basis to believe can be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, and payment for those services. This notice tells how your PHI is used and shared by DCH and Plan Representatives. DCH follows the information privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Only Summary Information is Used When Developing and/or Modifying the Plan. The Board of Community Health, which is the governing Board of DCH, the Commissioner of DCH and the Chief of the Plan administer the Plan and make certain decisions about the Plan. During those processes, they may review certain reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any individual person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its workforce, DCH may provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce. This Summary Health Information may only be used by your employer to obtain health insurance quotes from other sources and make decisions about whether to continue to offer the Plan. Please note that DCH, Plan Representatives, and your employer are prohibited by law from using any PHI that includes genetic information for underwriting purposes.

Plan "Enrollment Information" and "Claims Information" are Used in Order to Administer the Plan. PHI includes two kinds of information, "Enrollment Information" and "Claims Information". "Enrollment Information"

includes, but is not limited to, the following types of information regarding your plan enrollment: (1) your name, address, email address, social security number and all information that validates you (and/or your Spouse and Dependents) are eligible or enrolled in the Plan; (2) your Plan enrollment choice; (3) how much you pay for premiums; and (4) other health insurance you may have in effect. There are certain types of "Enrollment Information" which may be supplied to the Plan by you or your personal representative, your employer, other Plan vendors or other governmental agencies that may provide other benefits to you. This "Enrollment Information" is the only kind of PHI your employer is allowed to obtain. Your employer is prohibited by law from using this information for any purpose other than assisting with Plan enrollment.

"Claims Information" includes information your health care providers submit to the Plan. For example, claims information may include medical bills, diagnoses, statements, x-rays or lab test results. It also includes information you may submit or communicate directly to the Plan, such as health questionnaires, biometric screening results, enrollment forms, leave forms, letters and/or telephone calls. Lastly, it includes information about you that may be created by the Plan. For example, it may include payment statements and/or other financial transactions related to your health care providers.

Your PHI is Protected by HIPAA. Under HIPAA, employees of DCH and employees of outside companies and other vendors hired or contracted either directly or indirectly by DCH to administer the Plan are "Plan Representatives," and therefore must protect your PHI. These Plan Representatives may only use PHI and share it as allowed by HIPAA, and pursuant to their "Business Associate" agreements with DCH to ensure compliance with HIPAA and DCH requirements.

DCH Must Ensure the Plan Complies with HIPAA. As the Plan sponsor and administrator, DCH must make sure the Plan complies with all applicable laws, including HIPAA. DCH and/or the Plan must provide this notice, follow its terms and update it as needed. Under HIPAA, Plan Representatives may only use and share PHI as allowed by law. If there is a breach of your PHI, DCH must notify you of the breach.

Plan Representatives Regularly Use and Share your PHI in Order to Administer the Plan. Plan Representatives may verify your eligibility in order to make payments to your health care providers for services rendered. Certain Plan Representatives may work for contracted companies assisting with the administration of the Plan. By law, these Plan Representative companies also must protect your PHI.

HIPAA allows the Plan to use or disclose PHI for treatment, payment, or health care operations. Below are examples of uses and disclosures for treatment, payment and health care operations by Plan Representative Companies and PHI data sharing.

Claims Administrator Companies: Plan Representatives process all medical and drug claims; communicate with the Plan Members and/or their health care providers.

Wellness Program Administrator Companies: Plan Representatives administer Well-Being programs offered under the Plan communicate with the Plan Members and/or their health care providers.

Actuarial, Health Care and /or Benefit Consultant Companies: Plan Representatives may have access to PHI in order to conduct financial projections, premium and reserve calculations, and financial impact studies on legislative policy changes affecting the Plan.

State of Georgia Attorney General's Office, Auditing Companies and Outside Law Firms: Plan Representatives may provide legal, accounting and/or auditing assistance to the Plan.

Information Technology Companies: Plan Representatives maintain and manage information systems that contain PHI.

Enrollment Services Companies: Plan Representatives may provide the enrollment website and/or provide customer service to help Plan Members with enrollment matters.

Note: Treatment is not provided by the Plan but we may use or disclose PHI in arranging or approving treatment with providers.

Under HIPAA law, all employees of DCH must protect PHI and all employees must receive and comply with DCH HIPAA privacy training. Only those DCH employees designated by DCH as Plan Representatives for the SHBP health care component are allowed to use and share your PHI.

DCH and Plan Representatives May Make Uses or Disclosures Permitted by Law in Special Situations.

HIPAA includes a list of special situations when the Plan may use or disclose your PHI without your authorization as permitted by law. The Plan must track these uses or disclosures. Below are some examples of special situations where uses or disclosures for PHI data sharing are permitted by law. These include, but are not limited to, the following:

Compliance with a Law or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law or to prevent a serious threat to health and safety.

Public Health Activities: The Plan may give PHI to other government agencies that perform public health activities.

Information about Eligibility for the Plan and to Improve Plan Administration: The Plan may give PHI to other government agencies that may provide you benefits (such as state retirement systems) in order to get information about your eligibility for the Plan and to improve administration of the Plan.

Research Purposes: Your PHI may be given to researchers for a research project, when the research has been approved by an institutional review board. The institutional review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you and/or with your legal personal representative. However, the Plan may provide limited information to the employee about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. Plan Representatives may not use or share your PHI for any reason that is not described in this notice without a written authorization by you or your legal representative. For example, use of your PHI for marketing purposes or uses or disclosures that would constitute a sale of PHI are illegal without this written authorization. If you give a written authorization, you may revoke it later.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to Inspect and Obtain a Copy your Information, Right to Ask for a Correction: You have the right to obtain a copy of your PHI that is used to make decisions about you. If you think it is incorrect or incomplete, you may contact the Plan to request a correction.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of all special uses and disclosures.

Right to Ask for a Restriction of Uses and Disclosures, or for Special Communications: You have the right to ask for added restrictions on uses and disclosures, but the Plan is not required to agree to a requested restriction, except if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and pertains solely to a health care item or service that you or someone else on your behalf has paid in full. You also may ask the Plan to communicate with you at a different address or by an alternative means of communication in order to protect your safety.

Right to a Paper Copy of this notice and Right to File a Complaint: You have the right to a paper copy of this notice. Please contact the SHBP Call Center at 1-800-610-1863 or you may download a copy at www.dch.georgia.gov/shbp. If you think your HIPAA privacy rights may have been violated, you may file a complaint. You may file the complaint with the Plan and/or the U.S. Department of Health & Human Services, Office of Civil Rights, Region IV. You will never be penalized by the Plan or your employer for filing a complaint.

Address to File HIPAA Complaints:

Georgia Department of Community Health
SHBP HIPAA Privacy Unit
P.O. Box 1990
Atlanta, GA 30301
1 800 610 1863

U.S. Department of Health & Human Services
Office for Civil Rights
Region IV
Atlanta Federal Center
61 Forsyth Street SW
Suite 3B70
Atlanta, GA 30303-8909
1 877 696 6775

For more information about this Notice, contact:
Georgia Department of Community Health
State Health Benefit Plan
P.O. Box 1990
Atlanta, GA 30301
1 800 610 1863

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OPT-OUT NOTICE

Election to be Exempt from Certain Federal law requirements in title XXVII of the Public Health Service Act

September 25, 2014

TO: All Members of the State Health Benefit Plan who are not Enrolled in a Medicare Advantage Option

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Your plan option is self-funded because the Department of Community Health (DCH) pays all claims directly instead of buying a health insurance policy.

The Department of Community Health has elected to exempt your State Health Benefit Plan from the Mental Health Parity and Addiction Equity Act, that includes protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the Plan.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2015 and ending December 31, 2015. The election may be renewed for subsequent plan years.

Centers for Medicare & Medicaid Services

Medicare Part D Creditable Coverage Notice

Important Notice from the Department of Community Health about Your 2015 Prescription Drug Coverage under the State Health Benefit Plan HRA Options and Medicare for Plan Year: January 1 – December 31, 2015

Please read this notice carefully and keep it where you can find it. This notice has information about your current Prescription Drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's Prescription Drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in your area. Information about where you can get help to make decisions about your Prescription Drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's Prescription Drug coverage:

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Department of Community Health has determined that the Prescription Drug coverage offered under SHBP is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is, therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable Prescription Drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period ("SEP") to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Part D Drug Plan?

If you decide to join a Medicare drug plan, your current SHBP coverage will be affected. If you join a Medicare drug plan and do not terminate your SHBP coverage, SHBP will coordinate Benefits with the Medicare drug plan coverage the month following receipt of the notice. You should send a copy of your notice to SHBP at: P.O. Box 1990, Atlanta, GA 30301-1990.

IMPORTANT: If you are a retiree and terminate your SHBP coverage, you will not be able to get this SHBP coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go sixty-three (63) continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare Prescription Drug coverage. In addition, if you don't join within 63 continuous days after your current coverage ends, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the SHBP Call Center at: 1-800-610-1863.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHBP changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer Prescription Drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare Prescription Drug coverage:

- Visit: www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE at: 1-800-633-4227 (TTY 1-877-486-2048)

If you have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security on the web at: www.socialsecurity.gov or call at 1-800-772-1213 (TTY: 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

From: January 1, 2015 **To:** December 31, 2015

Date: September 25, 2014

Summaries of Benefits and Coverage

Summaries of benefits and coverage describe each Plan option in the standard format required by the Affordable Care Act. These documents are posted here: <http://dch.georgia.gov/shbp-plan-documents>. To request a paper copy, you may call 1-800-610-1863.

Georgia Law Section 33-30-13 Notice:

Member premiums for the HMO and HDHP options reflect new plan designs and discounts. Some members will experience premium increases as a result of their choices for 2015, while some will experience premium decreases. Since some members will experience a premium increase, DCH provides the following notice: “SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is 2.6% higher than it would be if the Affordable Care Act provisions that take place in 2015 did not apply.”

Through effective planning, purchasing and oversight, the Georgia Department of Community Health (DCH) provides access to affordable, quality health care to millions of Georgians, including some of the state’s underserved and most vulnerable populations. DCH is responsible for Medicaid and PeachCare for Kids®, the State Health Benefit Plan, Healthcare Facility Regulation and Health Information Technology in Georgia. Clyde L. Reese III, Esq., serves as Commissioner for the Georgia Department of Health. To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov.