BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC.

# SmartSense Individual Open Access Point of Service (POS) Member Contract

## $1,500

## Maternity is NOT Covered

**Except for Accidental Injury or Medical Emergency treatment out-of-pocket expenses are up to 20% higher when you receive care from a Non-Network Provider.**

## Individual Member Contract

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

We want you to understand the terms of this Contract. As you read through it, remember "we", "us" and "our" refer to Blue Cross Blue Shield Healthcare Plan of Georgia. We use the words "you and "your" to mean each covered Member.

**Refund Upon Examination**--You have 30 days to read this Contract. If you change your mind and decide you do not want this Contract, you may return it, along with a written request for cancellation within 30 days and any Premiums which you have paid will be returned to you. At that time, you will have no further obligation. This Contract explains the benefits payable. Your only obligation is to pay the Premiums on time. Remember, if you decide you do not want the Contract, we will not cover any claims you may have during the 30-day period.

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

The Effective Date of this Contract is the date assigned by BCBSHP. After your first payment to BCBSHP (called "Premiums"), the Contract shall be in force until your next payment is due. All payments have a 31-day grace period which is explained in more detail below and also in another section called "General Provisions". Please note, however, that you are not covered until BCBSHP receives your first payment and you are approved for coverage. All payments after the first one must be paid **on or before** the date they are due (BCBSHP calls this date the "**due date**").

The amount of your payment will be changed automatically based on your area and age, gender and type of coverage. You will be notified 60 days before any change is made.

Except for your first payment, you have a 31-day grace period beyond the due date to pay. Your Contract remains in effect during this 31 days. If you do not make a payment within this 31-day grace period, BCBSHP has the right to refuse to accept your payment and automatically cancel your Contract.

You may be charged a monthly fee by BCBSHP for receiving a paper bill. Contact Customer Service for more information. You will be responsible for a service charge for any check which is returned or dishonored by the bank as non-payable to BCBSHP for any reason.

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

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

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

**Monye Connolly**
**President**

# Table of Contents

**Summary of Benefits** ........ ix
**Important Phone Numbers and Web Address** ........ ix

**1. ELIGIBILITY** ........ **1**

1.1 Coverage for You ........ 1
1.2 Coverage for Your Dependents ........ 1
1.3 Your eligible Dependents include: ........ 1
1.4 How to Enroll ........ 1
1.5 When Your Coverage Begins ........ 1
1.6 Types of Coverage ........ 1
1.7 Changing Your Coverage (Adding a Dependent) ........ 2
1.8 Marriage and Stepchildren ........ 3
1.9 Newborn and Adopted Children ........ 2
1.10 Changing Your Coverage or Removing a Dependent ........ 2

**2. HOW YOUR BENEFITS WORK FOR YOU** ........ **3**

2.1 Capitalized Terms ........ 3
2.2 Your Network Provider Contract ........ 3
2.3 Copayment ........ 3
2.4 Consumer Choice Option – (Please note the following applies only if you purchased the Consumer Choice Option at enrollment) ........ 3
2.5 Deductibles ........ 4
2.6 What Your Coverage Covers ........ 5
2.7 Mental Health Care and Substance Abuse Treatment ........ 6
2.8 Lifetime Maximum Benefits ........ 6
2.9 Special Requirements ........ 7
2.10 Capped Benefits ........ 7

**3. PRE-ADMISSION CERTIFICATION (PAC) HOSPITAL PRE-CERTIFICATION** ........ **8**

3.1 Pre-Admission Certification (PAC) is a requirement for both In-Network and Out-of-Network benefits. ........ 8
3.2 The Pre-Admission Certification Process ........ 8
3.3 In-Network ........ 8
3.4 Out-of-Network ........ 8
3.5 Pre-Certification is a guarantee of payment. ........ 8
3.6 Outpatient Pre-certification Requirements ........ 9

**4. BENEFITS** ........ **10**

4.1 Payment Terms ........ 10
4.2 Physician Services ........ 10
4.3 Preventive Services, Mammograms, Pap Smear Examinations, Prostate Antigen Tests and Chlamydia Screening Tests ........ 10



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4.4 Child Wellness Services ........ 11
4.5 Inpatient Hospital Services ........ 11
4.6 Non-Network Hospital Benefits ........ 12
4.7 Outpatient Hospital Services ........ 12
4.8 Emergency Room Care: Life-threatening Medical Emergency or Serious Accidental Injury ........ 12
4.9 Telemedicine ........ 12
4.10 Outpatient Diagnostic Services ........ 12
4.11 Other Covered Services ........ 13
4.12 Mental Health Care and Substance Abuse Treatment ........ 29

**5. LIMITATIONS AND EXCLUSIONS ........ 32**

5.1 Pre-existing Conditions ........ 32
5.2 Excess Coverage Provision ........ 32
5.3 Governmental Programs ........ 32
5.4 Exclusions ........ 32

**6. MEMBER RIGHTS AND RESPONSIBILITIES ........ 38**

6.1 Your rights as a Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Member ........ 38
6.2 Your responsibilities as a Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Member ........ 38

**7. GENERAL PROVISIONS ........ 40**

7.1 Entire Contract and Changes ........ 40
7.2 Time Limit on Certain Defenses ........ 40
7.3 Grace Period ........ 40
7.4 Reinstatement ........ 40
7.5 Notice of Claims, Proof of Loss and Claim Forms ........ 40
7.6 Balance Billing ........ 41
7.7 Time of Payment of Claims ........ 41
7.8 Physical Examinations ........ 41
7.9 Legal Action ........ 41
7.10 Assignment of Benefits ........ 41
7.11 Unreasonable Fees ........ 41
7.12 Compliance with Given Provisions ........ 41
7.13 Renewability ........ 41
7.14 Change in Premium Charge ........ 41
7.15 Unpaid Premium ........ 42
7.16 Applicable Law ........ 42
7.17 Care Received Outside the United States ........ 42
7.18 Licensed Controlled Affiliate ........ 42
7.19 BlueCard ........ 42
7.20 Liability Calculation Method Per Claim ........ 43
7.21 Return of Overpayments ........ 43



**Questions? Visit www.MediCoverage.com or call (800) 930-7956**

**8. PAYMENT OF BENEFITS; GENERAL INFORMATION ..... 44**

8.1 Hospital Services ..... 44
8.2 Physician Services ..... 44
8.3 Network or Participating Provider Information ..... 44
8.4 Other Services or Supplies ..... 44
8.5 Contract Administration ..... 44
8.6 Unauthorized Use of Identification Card; Fraudulent Statements ..... 45
8.7 Questions About Coverage or Claims ..... 45
8.8 Explanation of Benefits ..... 45
8.9 We Want You To Be Satisfied ..... 45
8.10 Summary of Grievances ..... 46
8.11 Terms of Your Coverage ..... 46
8.12 Acts Beyond Reasonable Control (Force Majeure) ..... 46

**9. WHEN YOUR COVERAGE TERMINATES ..... 47**

9.1 Termination of Coverage ..... 47
9.2 End of Coverage ..... 47
9.3 Conversion ..... 47
9.4 Services After Cancellation of Coverage or Amendment of Policy ..... 47

**10. CONDITIONS OF BENEFITS PROVISION ..... 49**

10.1 Hospital Inpatient Benefits ..... 49
10.2 Right to Receive Necessary Information ..... 49

**11. NOTICE ..... 50**

11.1 Change Notification - Members ..... 50
11.2 Change Notification - Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. ..... 50

**12. DEFINITIONS ..... 51**

Network Hospital ..... 57
Network Provider ..... 57
Specialty Pharmacy ..... 59



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| Summary of Benefits | In-Network | Out-of-Network |
|---|---|---|
| This **Summary of Benefits** explains the extent to which Covered Services are available to covered persons on this Contract. Your Copayment, Coinsurance, maximums and limits for Covered Services are shown below and are per covered person. This Summary is not a complete explanation of these benefits. To understand them, you must read this **Summary of Benefits** and your Contract. All Covered Services shall be provided subject to all terms and conditions stated in the Contract. | | |
| **Lifetime Maximums** | | |
| **Lifetime Maximum Benefits**<br>**All benefits combined:** In-Network and Out-of-Network | $5,000,000 | |
| **Lifetime Maximum Benefits for TMJ** (included in total maximum)<br>In-Network and Out-of-Network combined | $5,000 | |
| **Lifetime Maximum Benefits for Hospice Care** (included in total maximum)<br>In-Network and Out-of-Network combined | $10,000 | |
| **Calendar Year Deductible**<br>**All services are subject to a Deductible per Benefit Period unless otherwise stated. No benefits are payable until the Calendar Year Deductible is satisfied.** | | |
| **Deductible**<br>**Aggregate Deductible** | $1,500<br>$3,000 | $1,500<br>$3,000 |
| All services and all calendar year maximums – whether for a number of days or visits, treatments or a yearly dollar limit – are subject to the Lifetime Maximum Benefit. | | |
| **Out-of-Pocket Limit** | | |
| **Out-of-Pocket Limit Per Benefit Period** | $4,500 | $9,000 |
| **Aggregate Family Out-of-Pocket Limit Per Benefit Period** | $9,000 | $18,000 |
| All Eligible Charges including Deductible apply towards the Out-of-Pocket Limit. Copayments do not apply towards the Out-of-Pocket Limit. | | |
| **All In-Network care must be received from a Network Provider.** | | |



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| **Summary of Benefits**<br>***Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance*** | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Percentage Payable** (Unless Otherwise Specified) | | |
| All payments are based on Eligible Charges and negotiated fees. | | |
| BCBSHP covers | 70% | 50% |
| The Member pays | 30% | 50% |
| The percentage BCBSHP covers after the Out-Of-Pocket Limit is met | 100% | 100% |
| **Hospital Inpatient Services** | | |
| Room and Board (Semiprivate or ICU/CCU) | 70% | 50% |
| Hospital services and supplies (x-ray, lab, anesthesia, etc.) | 70% | 50% |
| Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 70% | 50% |
| **Pre-Admission Certification is required for all Hospital Admissions except for Medical Emergencies.** | | |
| **Outpatient Hospital Services** | | |
| Outpatient Surgery, Facility, etc. | 70% | 50% |
| Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 70% | 50% |
| Outpatient Diagnostics | 70% | 50% |
| Ambulatory Surgery Center | 70% | 50% |
| **Outpatient Pre-certification required for specified procedures.** | | |



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| Summary of Benefits<br>*Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance* | In-Network | Out-of-Network |
|---|---|---|
| Accidental Injury or Medical Emergency<br>$500 Copayment is waived if admitted to the Hospital. | $500 Copayment | $500 Copayment |
| Non-Accidental Injury or Non-Medical Emergency | 70% | 50% |
| Initial services rendered for the onset of symptoms for a life-threatening medical condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. | | |
| **Professional Ambulance Service** | 70% | 70% |
| **Air Ambulance** | 70% | 70% |
| **Inpatient Mental Health Care and Substance Abuse Treatment**<br>30 days per person per calendar year, combined, In-network and Out-of-network | 70% | 50% |
| **Outpatient Mental Health Care and Substance Abuse Treatment**<br>48 visits per person per calendar year, combined, In-network and Out-of-network | 70% | 50% |
| **<u>Physician Office Services –</u> Office visits only, on an outpatient basis – including Preventive Care**<br>**First 3 visits** per member per calendar year | $30 Copayment | 50% |
| **After 3 visits**<br>For children through age 5, the deductible does NOT apply<br>• Periodic Health Assessments<br>• Developmental Assessment of the Child. | 70%<br>Deductible waived | 50%<br>Deductible waived |
| All other visits | 70% | 50% |
| **<u>Preventive Care Services – children through age 5</u>**<br>• Age appropriate immunizations<br>• Laboratory testing<br>The Deductible does NOT apply for children through age 5 (In-network or Out-of-network). | 70%<br>Deductible waived | 50%<br>Deductible waived |



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| **Summary of Benefits**<br>***Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance*** | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Preventive Care Services – age 6 and older**<br>Services include, but are not limited to (Pap Smears, Chlamydia screenings, Ovarian Surveillance)<br>• Mammography (not subject to Deductible) | 100% Deductible waived | Not Covered |
| • Immunizations, PSA test, screenings performed in the office (not subject to Deductible) | 70% Deductible waived | Not Covered |
| • Outpatient procedures-services include, but not limited to: colonoscopy | 70% | Not Covered |
| **Home Health Care Services**<br>100 Home Health Care visits per person per benefit period, combined In-network and Out-of-network. | 70% | 50% |
| **Skilled Nursing Facility**<br>30 days per person per calendar year, combined In-and Out-of-Network | 70% | 50% |
| **Hospice Care Services**<br>$10,000 Lifetime Maximum combined In-network and Out-of-network | 70% | 50% |
| **Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers**<br>30 visits per person, per calendar year, combined specialties combined In-network and Out-of-Network | 70% | 50% |
| **Radiation Therapy / Chemotherapy** | 70% | 50% |
| **Speech Therapy**<br>30 visits per person per calendar year, combined In-network and Out-of-Network | 70% | 50% |
| **Respiratory Therapy**<br>30 visits per person per calendar year, combined In-network and Out-of-network | 70% | 50% |
| **Private Duty Nursing (RN or LPN)**<br>$2,500 per person per calendar year, combined In-network and Out-of-network | 70% | 50% |
| **Wigs and Cranial Prosthetics** | | |



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| **Summary of Benefits** *Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance* | **In-Network** | **Out-of-Network** |
|---|---|---|
| $500 per person per calendar year, combined In-network and Out-of-network | 70% | 50% |
| **Durable Medical Equipment** | 70% | 50% |
| **All other covered medical expenses** | 70% | 50% |



**Questions? Visit www.MediCoverage.com or call (800) 930-7956**

| Summary of Benefits<br>*Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance* | In-Network | Out-of-Network |
|---|---|---|
| **Prescription Drug Benefits** | | |
| A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a Prescription Drug requires pre-authorization, please call Customer Service. | | |
| **Retail Pharmacy**<br>34-day supply | | |
| Tier 1 - Low cost or preferred medications.<br>Generally generic. May include single source brand drugs, or multi-source brand drugs. Not subject to Deductible. | $15 Copayment | $15 Copayment |
| Tier 2 – Moderate cost, preferred medications.<br>$500 deductible per person per calendar year. Generic required if available, not subject to Deductible. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance. May include generic, single source brand drugs or multi-source brand drugs. | $30 Copayment | $30 Copayment |
| Tier 3 – Non-preferred or high cost medications.<br>$500 deductible per person per calendar year. Generic required if available, not subject to Deductible. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance. May include generic, single source brand drugs or multi-source brand drugs. | $60 Copayment | $60 Copayment |
| Tier 4 – Typically high-cost, injectable, infused, oral or inhaled medications.<br>(Must use a Network Specialty Pharmacy. $500 deductible per person per calendar year. $4000 out-of-pocket maximum per person per year. Generic required if available. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance | 40% Coinsurance | 40% Coinsurance |
| **Mail Order – Maintenance Only**<br>90-day supply | | |
| Tier 1 - Low cost or preferred medications.<br>Generally generic. May include single source brand drugs, or multi-source brand drugs. Not subject to Deductible. | $30 Copayment | $30 Copayment |
| Tier 2 – Moderate cost, preferred medications.<br>$500 deductible per person per calendar year. Generic required if available, not subject to Deductible. If brand name is selected, Member will pay the difference between the brand and generic | $75 Copayment | $75 Copayment |

| Summary of Benefits<br>*Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance* | In-Network | Out-of-Network |
|---|---|---|
| Eligible Charge plus any brand Copayment and Coinsurance. May include generic, single source brand drugs or multi-source brand drugs. | | |
| Tier 3 – Non-preferred or high cost medications.<br>$500 deductible per person per calendar year. Generic required if available, not subject to Deductible. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance. May include generic, single source brand drugs or multi-source brand drugs. | $150 Copayment | $150 Copayment |
| Tier 4 – Typically high-cost, injectable, infused, oral or inhaled medications.<br>(Must use a Network Specialty Pharmacy. $500 deductible per person per calendar year. $4000 out-of-pocket maximum per person per year. Generic required if available. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance | 40% Coinsurance | 40% Coinsurance |



Questions? Visit www.MediCoverage.com or call (800) 930-7956

## Verification of Benefits

Verification of Benefits is available for Members or authorized healthcare providers on behalf of Members. You may call Customer Service with a **benefits inquiry** or **Verification of Benefits** during normal business hours. Please remember that a **benefits inquiry** or **Verification of Benefits** is Not a Verification of Coverage of a specific medical procedure.

- **Verification of Benefits is NOT a guarantee of payment.**
- **If the verified service requires pre-certification, please call 1-800-722-6614.**

**Pre-Admission Certification .................................................................................................................. Required**

- Required for ALL Hospital admissions except emergency admissions. Please notify BCBSHP within 48 hours of an emergency.
- Non-urgent/elective pre-certification can be requested during normal business hours.
- The phone number for pre-certification is **1-800-722-6614.**
- Emergency services do **NOT** require pre-certification.
- Pre-Admission Certification (PAC) is a guarantee of payment and determinations are available by phone through BCBSHP's pre-certification staff 24 hours a day, seven days a week for urgent/non-elective care that must be performed within 24 hours after the PAC request, without which a significant threat to the patient's health or well-being will be posed. BCBSHP will pay up to the reimbursement level of this Contract when the Covered Services are performed within the time limits assigned by PAC) **except for the following situations:**
  - The Member is no longer covered under this Contract at the time the services are received;
  - The benefits under this Contract have been exhausted (examples of this include day limits or maximum amounts);
  - No benefits will be paid in cases of fraud.

Pre-certification approvals apply only to services which have been approved in the pre-certification process and only as described in the approval. Such approval does not apply to any other services. Payment or authorization of such a service does not require or apply to payment of claims at a later date regardless of whether such later claims have the same, similar or related diagnoses.

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



Questions? Visit www.MediCoverage.com or call (800) 930-7956

## Important Phone Numbers and Web Address

**Pre-Admission Certification (PAC)**
The Hospital, your Physician, or you should call:
1-800-722-6614

**Customer Service**
If you have a customer service question, please call:
1-800-718-8831



**Questions? Visit www.MediCoverage.com or call (800) 930-7956**

# 1. Eligibility

## 1.1 Coverage for You

This Contract describes the benefits you may receive under your health care program. You are called the Subscriber or Member or insured.

## 1.2 Coverage for Your Dependents

1. You may enroll your eligible Dependents. Your Covered Dependents are also called Members.
2. If the wrong birthdate of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Any overpayments made for coverage for any child under these conditions will be refunded by either you or BCBSHP.

## 1.3 Your eligible Dependents include:

- Your wife or husband, or Domestic Partner;
- Your unmarried dependent children until attaining age 19, legally adopted children from the date you assume legal responsibility, and step children. Also included are your children (or children of your spouse or Domestic Partner) for whom you have legal responsibility resulting from a valid court decree. Children may be covered up to and including age 25 provided they remain your Dependents and, in each calendar year since reaching age 19, are enrolled as full-time students in a post-secondary institution of higher learning for five calendar months or more; or, if not enrolled, would have been eligible to enroll, but were prevented due to illness or Injury; Unmarried children who are mentally or physically handicapped and totally dependent on you for support, regardless of age with the exception of incapacitated children age 19 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Contract prior to reaching age 19. Certification of the handicap is required within 31 days of attainment of age 19. A certification form is available from BCBSHP and may be required periodically but not more frequently than annually after the two-year period following the child's attainment of the limiting age.
- Your unmarried dependent children not on active duty with any branch of the Armed Services.

## 1.4 How to Enroll

You must give evidence of insurability (at your expense) to BCBSHP for yourself and your Dependents in order to be covered. This means you must pass medical underwriting requirements in order to be covered.

## 1.5 When Your Coverage Begins

Eligibility for coverage and the Effective Date for any Member will be decided by BCBSHP after the Application for Coverage is return and it is approved. This rule also applies to any later changes of coverage.

## 1.6 Types of Coverage

- Subscriber – Coverage for you only
- Couple – Coverage for you and your spouse or Domestic Partner
- Subscriber and one eligible child – Coverage for you and one eligible child
- Subscriber and two or more eligible children – Coverage for you and two or more eligible children
- Family Coverage – Coverage for you, your spouse or Domestic Partner and all eligible children



**Questions? Visit www.MediCoverage.com or call (800) 930-7956**

## 1.7 Changing Your Coverage (Adding a Dependent)

You may add new Dependents by contacting BCBSHP in writing. Coverage is provided only for those Dependents you have reported to BCBSHP by completing the correct application.

Please contact us for an "Addition of Dependents" form for each Dependent you wish to add to your Contract. We require medical information for Dependents other than newborns.

Once we accept your Application for the Dependent's coverage, we assign an Effective Date to the new coverage for that person. The new covered person's Waiting Period begins at this Effective Date, unless that new covered person is an adopted child of the Subscriber. Newly added adopted Dependent children of a Subscriber do not serve a Waiting Period.

## 1.8 Marriage and Stepchildren/Domestic Partner and Eligible Children

In order for a Member to add a spouse and eligible stepchildren upon marriage, or if a Member wishes to add a domestic partner and eligible children, evidence of insurability must be provided to BCBSHP for the spouse and stepchildren or domestic partner and eligible children. Such evidence must be furnished at the Member's expense. BCBSHP may approve or reject the new spouse or domestic partner and stepchildren or eligible children based on the evidence of insurability. If an application is approved, the Effective Date will be the first of the month following medical underwriting approval. If an application is rejected, that person will not be a covered Member under the Contract.

## 1.9 Newborn and Adopted Children

We automatically cover the Subscriber's newborn and/or an adopted child for 31 days from the date of birth, from placement or final decree, which occurs first. In order for a newborn child or an adopted child to have coverage past 31 days, a change-of-coverage form must be submitted within 31 days of the date of birth or within 31 days of the date the Member assumes legal responsibility. If you do not apply within 31 days, the child must meet evidence of insurability requirements (at your expense). BCBSHP may approve or reject the child based on the medical information you submit. If the application is approved, the Effective Date will be decided by BCBSHP.

You must pay the required additional premium (if any). If the application is rejected, the newborn or adopted child will not be a covered Member under the Contract.

## 1.10 Changing Your Coverage or Removing a Dependent

When any of the following events occur, notify BCBSHP and ask for the appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 19 or marries (see "When Your Coverage Terminates");
- Enrolled dependent child becomes permanently disabled;
- When a covered person begins active duty with the Armed Services;
- At the Member's request;
- When a Domestic Partner relationship no longer exists.



**Questions? Visit www.MediCoverage.com or call (800) 930-7956**

# 2. How Your Benefits Work For You

## 2.1 Capitalized Terms

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

## 2.2 Your Network Provider Contract

This Contract is a comprehensive plan that provides Physician and Specialist health care services. All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied. A Member has direct access to primary and specialty care directly from any In-Network Physician.

Physicians and Hospitals participating in our Networks are compensated using a variety of payment arrangements, including capitation, fee for service, per diem, discounted fees, and global reimbursement.

This Contract provides Point-of-Service Benefits
This Contract is a comprehensive benefit plan called “Point-of-Service.” This means that you have a choice when you go to a Physician, Hospital or other provider of health care. The Contract is divided into two sets of benefits: In-network and Out-of-network. If you choose In-network benefits, you are directed to any necessary services through your Physician who coordinates your health care. If you choose Out-of-network benefits, you will pay more. Each time you visit a provider, you will have that choice to make. That’s why it’s called Point-of-Service.

## 2.3 Copayment

1. Whether you choose In-Network or Out-of-Network benefits, you may be charged a Copayment amount for certain services, that may be a flat-dollar amount or a percentage of the total charge.
2. Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Summary of Benefits**.
3. Network Providers’ services which are not specifically identified in this Contract as subject to Copayment are subject to the calendar year Deductible and if applicable, Coinsurance, as stated in the **Summary of Benefits**.

## 2.4 Consumer Choice Option – (Please note the following applies only if you purchased the Consumer Choice Option at enrollment)

The Consumer Choice Option allows you to nominate an Out-of-Network Provider (limited to a Physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advance practice nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, qualified athletic trainer (per OCGA 43-5-8), occupational therapist, speech language pathologist, audiologist, dietitian, Physician’s assistant or Hospital) for specified Covered Services. Such nominated providers must be approved in writing by BCBSHP. and are subject to the normal rules and conditions which apply to a contracted Network Provider. These terms include reimbursement (who we pay and how much), utilization management protocols (pre-certification procedures and our internal procedures enabling us to pay for Covered Services), Prescription Drug Formulary compliance (making sure we pay for drugs on our approved list), Referral to Network or Non-Network Providers, and other internal procedures which BCBSHP normally follows. All Non-Network Providers must be nominated, agree to participate and be approved.

Please remember that, while you may obtain benefits at In-Network levels from an approved, nominated provider, these providers have not gone through BCBSHP’s rigorous credentialing process, and they are not subject to BCBSHP’s quality assurance standards.

The nominated provider is not an In-Network Provider and has not been credentialed by BCBSHP. The Member alone is responsible for the selection of the nominated provider and BCBSHP has not undertaken any credentialing or quality assurance measures regarding such nominated provider. BCBSHP will not undertake to conduct routine quality assurance measures which are used for In-Network Providers. The Member should understand that any and all Physicians, Hospitals and any others who are not In-Network Providers must be nominated by the Member (patient) and approved by BCBSHP prior to any services being performed by the provider in order for the services to become eligible for reimbursement at In-Network benefit levels. For additional information, please contact your Plan Administrator.

**Provider Nomination**

Under the Consumer Choice Option, you may nominate any Hospital or provider listed above licensed to practice in the state of Georgia to render specified Covered Services. However, you do **not** have free unrestricted access to non-nominated providers or to providers who have been nominated by you but not yet approved by BCBSHP.

The nomination process includes several steps:

- You may obtain copies of the nomination form by calling 1-800-441-2273.
- Complete and sign the first section of the nomination form and give to your provider.
- The provider signs the second part of the form, indicating they may be interested in acting as your provider, subject to BCBSHP's terms and conditions. The provider requests authorization for specific procedures (or ongoing medical treatment). The provider submits the form to BCBSHP.
- Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. verifies the licensure of the provider and notifies the provider of the applicable fee schedule or potential reimbursement.
- The provider, after receiving the notice of the potential reimbursement, signs and returns the form to BCBSHP.
- BCBSHP notifies you and your provider if and when the fully completed form has been received and approved.

A decision will be made by BCBSHP within 3 days of the receipt of the fully completed nomination form. Please note that approval is made only for the requested procedures. Additional procedures must be requested and approved by BCBSHP.

It is important to remember that only after all these steps and all other Contract requirements have been followed are Covered Services paid when provided by a Non-Network Provider.

## 2.5 Deductibles

**Deductible**

Deductible, also called Calendar Year Deductible is a specified amount of Eligible Charges you must pay each Benefit Period before we cover benefits unless otherwise specified on your **Summary of Benefits**. Your Deductible is shown on your **Summary of Benefits**.

**In-Network vs. Out-of-Network**

Amounts you pay that we count toward your Deductible for an In-Network PPO Provider or In-Network PPO facility do not count toward meeting the separate Deductible if you then use a Out-of-Network Provider or Out-of-Network facility, and vice versa.

**Individual Deductible**

This is the Deductible amount that each covered person must satisfy per Benefit Period before we provide any benefits (subject to the Deductible exceptions listed throughout your **Summary of Benefits** and the Aggregate Deductible and One Accident - Two or More covered persons provisions below) for that covered person.

**Aggregate Deductible**

If you have Dependents covered under your policy, your **Summary of Benefits** will show an aggregate Deductible amount. All Member eligible charges are combined to meet the aggregate Deductible amount. However, no one person can contribute more than the individual Deductible to the aggregate Deductible.



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**Carryover Deductible**
Any Eligible Charges we apply toward your individual Deductible during the last three months of the Benefit Period will also be carried over to apply to the next Benefit Period. This action helps reduce your individual Deductible responsibility for that new Benefit Period.

**Copayments and Your Deductible**
Copayments never count toward meeting your Deductible.

**Deductibles, Date of Service, and Claim Filing**
We do not always receive claims in the order in which you received the services. We process claims in the sequence they are received in our office. To determine what monies count toward your Deductible, we look at the date of service on your claim form to determine the Benefit Period which is applicable for the claim. To determine what monies count toward your carryover Deductible, we look at the date of service.

**Drug Deductible**
Depending upon the Contract you purchased you may have a separate drug Deductible. Check your **Summary of Benefits** to see if this separate drug Deductible applies to you. This drug Deductible is the amount that each covered person must satisfy per Benefit Period before we provide any drug card benefits. This separate drug Deductible does not apply to, nor does it affect, your individual Deductible, aggregate Deductible, or carryover Deductible in any way.

**Changing Your Deductible**
Changing your Deductible may change the amount of Premium you pay us.

**To Increase Your Deductible**
You can increase your Deductible any time. Monies that we have already credited toward meeting your old Deductible will also apply toward the new, higher Deductible. Please contact our Customer Service Department for more information.

**To Decrease Your Deductible**
To qualify for a lower Deductible, you must meet our underwriting criteria. If you qualify, you have to meet your new Deductible, and meet a new Out-of-Pocket Limit. This means money you have paid toward the original Deductible and out-of-Pocket Limit will not count toward the new Deductible and new Out-of Pocket Limit. However, any portion of the calendar year Deductible met in the last quarter of the previous year will apply toward the new Deductible. This requirement applies to Covered Services with dates of service after the Effective Date of the lower Deductible. Covered Services with dates of service prior to the Effective Date of the lower Deductible will be subject to:

- the previous (higher) Deductible if the Deductible has not been met; and
- the previous Out-of-Pocket Limit.

## 2.6 What Your Coverage Covers

**Percentage Payable In-Network and Out-of-Network**

1. After the Deductible is met, the percentage payable by BCBSHP is stated in the **Summary of Benefits**. The portion which you must pay (the Out-of-Pocket amount) is stated in the **Summary of Benefits**. Once your separate out-of-pocket maximum for in-network or out-of-network services is reached eligible benefits for those network services are paid at 100% of the Eligible Charges during the remainder of the calendar year.
2. Eligible Charges are determined by: (a) BCBSHP's Usual, Customary, and Reasonable (UCR) Fees; (b) a provider's contracted fee schedule; (c) the applicable Reimbursement Rate; or (d) negotiated fees. Reimbursement for Network, Participating and Out-of-Network Providers is based on Eligible Charges for the type of service a Member receives (for example, Hospital or Physician services). Reimbursement for Non-Contracted Providers is determined by our Default Reimbursement Rate.



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3. The percentage of the bill payable is determined after Non-Covered Services have been deducted. For example, this Contract covers the charge for a Semiprivate Room. If you stay in a private room, you must pay the difference between these two charges.
4. In order to receive benefits, you must be admitted to a Hospital or receive treatment on or after your individual Effective Date and meet any applicable Deductible.

**Out-of-Pocket Limit**
Please read this section very carefully. Not all monies that you pay toward your health care costs are counted toward your in-network or out-of-network Out-of-Pocket Limit.

"Out-of-Pocket expense Limit" is what we call the maximum dollar amount that you pay towards certain Coinsurance before your Contract covers 100% of the Eligible Charge for certain services. Once you meet your Deductible and Out-of-Pocket Limit, your Contract will then cover 100% of most Eligible Charges. This dollar amount is shown on your **Summary of Benefits**.

Amounts we credit toward your Deductible count toward the Out-of-Pocket Limit. Also, the following items never count toward the Out-of-Pocket Limit and once your Out-of-Pocket Limit has been met, they are never paid at 100%:

- amounts paid for Prescription Drugs, including specialty drug and insulin;
- amounts exceeding the Eligible Charges;
- amounts over any Contract maximum or limitation; and
- expenses for services not covered under this Contract.

**Separate Out-of-Pocket Limit**
When you use an out-of-network Provider or out-of-network facility, we count your Coinsurance toward a separate Out-of-Pocket Limit. The limit amount is shown on your **Summary of Benefits**. If you wish to make the most effective use of your Coinsurance in meeting your Out-of-Pocket Limit, then use in-network PPO Providers and in-network PPO facilities.

**Aggregate Out-of-Pocket Limit**
If you have dependents covered under your policy, your **Summary of Benefits** will show an aggregate Out-of-Pocket Limit. All Member eligible charges are combined to meet the aggregate Out-of-Pocket Limit amount. However, no one person can contribute more than the individual Out-of-Pocket Limit to the aggregate Out-of-Pocket Limit.

## 2.7 Mental Health Care and Substance Abuse Treatment

There are some exceptions to what your coverage covers. One is for mental health care and substance abuse treatment. After the Deductible is met, BCBSHP will cover In-Network or Out-of-Network benefits based on the percentage payable stated in the **Summary of Benefits**. All mental health care and substance abuse treatment is subject to calendar year limits on the number of Inpatient days and visits. These limits are stated in the **Summary of Benefits**.

## 2.8 Lifetime Maximum Benefits

We set a lifetime maximum limit per covered person on the Contract benefits you receive for Covered Services. We do not cover more than the lifetime maximum limit. The policy lifetime maximum amount is shown on your **Summary of Benefits**. Your lifetime maximum is reduced by benefits you may have received under any previous BCBSHP and/or BCBSGA individual Contract. You may determine what your own benefit accumulation is toward this Contract's lifetime maximum by calling our Customer Service Department.



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It is important to understand that this lifetime maximum benefit accumulates from BCBSHP and/or BCBSGA individual Contract to BCBSHP and/or BCBSGA individual Contract. For example, if you have used $50,000 of your Contract's lifetime maximum, and then you change your coverage to another BCBSHP and/or BCBSGA individual Contract, we would count the $50,000 toward the new Contract's lifetime maximum.

If your coverage lapses, we do not reset your lifetime maximum with any BCBSHP and/or BCBSGA individual Contract you may subsequently purchase.

## 2.9 Special Requirements

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

## 2.10 Capped Benefits

This Contract has capped benefits. When we say "capped benefits", we mean certain benefits have dollar or visit limits that we will cover for those services. These amounts and visit limits are shown on your **Summary of Benefits**. Once you reach the dollar or visit limit for these benefits, the benefit ceases to exist as a Covered Service under this Contract for the remainder of the Benefit Period. Capped benefits under this Contract are:

- spinal manipulation and other manual medical interventions;
- mental health benefits;
- outpatient physical therapy;
- respiratory therapy;
- outpatient speech therapy;
- outpatient occupational therapy;
- home health care services;
- Skilled Nursing Facility stays;
- wigs and cranial prosthetics; and
- private duty nursing.

Any optional coverage you purchase to supplement this Contract's coverage may also have dollar or visit limits.



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# 3. Pre-Admission Certification (PAC) Hospital Pre-certification

## 3.1 Pre-Admission Certification (PAC) is a requirement for both In-Network and Out-of-Network benefits.

You, your Physician, or the Hospital must obtain Pre-Admission Certification of all Hospital admissions except Medical Emergencies. Pre-Admission Certification must also be obtained for Inpatient admissions for mental health care and substance abuse treatment.

## 3.2 The Pre-Admission Certification Process

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

## 3.3 In-Network

- If you are hospitalized other than for a Medical Emergency and Pre-Admission Certification was not obtained, the admitting Hospital will be responsible for the services. You – the Member – will be held harmless if all Network guidelines are followed and you were admitted to a Network Hospital. This means you will not be responsible for any bill in excess of the related Deductible, your percentage payable amounts and Non-Covered Services.
- If a Member exceeds the number of days assigned under this program, the Hospital's charges for additional days beyond the assigned length of stay will be denied. If all In-Network guidelines are followed, the Member will not be responsible for the charges except the normal Deductible, Coinsurance and Non-Covered Services.
- Charges for Non-Covered Services are always the Member's responsibility.
- PAC is the responsibility of the Network Hospital or Network Physician.

## 3.4 Out-of-Network

- You (the Member), the Physician or the Hospital must obtain approval for all Hospital admissions except for a Medical Emergency. This includes Inpatient admissions for mental health care and substance abuse treatment.
- If you are hospitalized other than in a Medical Emergency and Pre-Admission Certification was not obtained, there will be a $500 penalty applied before payment can be made. You will be responsible for this $500 in addition to any related Deductible and Coinsurance charges above UCR Fees and Non-Covered Services which may apply.
- If you obtained PAC but exceed the number of days allowed through the PAC process, you will be responsible for all of the charges for those days.
- Charges for Non-Covered Services are always the Member's responsibility.

## 3.5 Pre-Certification is a guarantee of payment.

Pre-Certification is a guarantee of payment and BCBSHP will pay up to the reimbursement level of this Contract when the Covered Services are performed within the time limits assigned by Pre-Admission Certification (PAC). Admissions are approved only when the appropriateness of the Inpatient setting can be substantiated. Actual payment is based upon eligibility for coverage and the effective date for any Member and also will be dependent on, but not limited to, your specific coverage and the status of the coverage on



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the date services are rendered. The program will not cover services related to specific Contract exclusions and limitations, including but not limited to Custodial Care, Experimental or Investigational procedures, pre-existing conditions during the waiting period and services determined not Medically Necessary.

## 3.6 Outpatient Pre-certification Requirements

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

Such services include, but are not limited to:

- Arthroscopy – shoulder & knee
- Biofeedback
- CT Scans
- Colonoscopy
- Echocardiography (if not ordered by a Cardiologist)
- Stress Thallium (if not ordered by a Cardiologist)
- Hysterectomy (under age 35)
- MRI and MRA
- Orthognathic/TMJ
- PET Scans
- Reconstructive Surgery

**This list is subject to change. Please call the number on your ID card to determine if a particular procedure or item requires pre-certification.**



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# 4. Benefits

Please refer to the **Summary of Benefits** for additional benefit information**.**

## 4.1 Payment Terms

Payment terms apply to all Covered Services. The following services are applicable to In-Network and Out-of-Network benefits. All Covered Services must be Medically Necessary, whether provided through In-Network Providers or Out-of-Network Providers.

## 4.2 Physician Services

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

## 4.3 Preventive Services, Mammograms, Pap Smear Examinations, Prostate Antigen Tests and Chlamydia Screening Tests

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

When you receive covered wellness and preventive services from either In-Network or Out-of-Network Providers, a Deductible may apply to the services. Please see your **Summary of Benefits**.

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

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

1. Benefits are provided for mammograms and the related office visit when provided by an eligible provider and performed with the following frequency:
   - Once as a base-line mammogram for any female between 35 and 40 years of age;
   - Once every two years for any female between 40 and 50 years of age;
   - Once every year for any female age 50 or above; and
   - When recommended by a Physician for a female considered at risk. Female at risk means a female:
     a. who has a personal history of breast cancer;
     b. who has a personal history of biopsy-proven benign breast disease;
     c. whose grandmother, mother, sister, or daughter has had breast cancer, or
     d. who has not given birth prior to age 30.
2. Pap Smear Examination
   Benefits will be provided for one Pap smear tissue examination per year, or when performed upon recommendation of a Physician.
3. Prostate Antigen Tests
   Benefits will be provided for annual prostate specific antigen tests and the related office visits for covered males who are 45 years of age or older, or covered males who are 40 years of age or older, if ordered by a Physician.



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4. Benefits are provided for one annual Chlamydia screening test and the related office visit for covered females who are not more than 29 years old; or covered females who are more than 29 years of age, if ordered by a Physician.

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

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

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

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

## 4.4 Child Wellness Services

1. Benefits are provided for child wellness services from birth through age five. These services are not subject to the calendar year Deductible. Covered Services are based on the standards for preventive pediatric health care published by the American Academy of Pediatrics.
2. Child wellness services include:
   a. Periodic Health Assessments (includes a medical history and appropriate physical exam);
   b. Developmental assessment of the child;
   c. Age appropriate immunizations;
   d. Laboratory testing.

## 4.5 Inpatient Hospital Services

You may receive treatment at a Network or Non-Network Hospital. However, payment is significantly reduced if services are received at a Non-Network Hospital. Your Contract provides Covered Services when the following services are Medically Necessary.

**Network Inpatient Hospital Benefits**

1. Room Allowance
   - If you are admitted to the Hospital, your coverage provides benefits for Inpatient care. This includes charges for Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, Eligible Charges are based on the Hospital's prevalent Semiprivate Room rate. If you are admitted to a Hospital that has only private rooms, Eligible Charges are based on the Hospital's prevalent room rate.
2. Service and Supplies
   - Your benefits cover services and supplies provided and billed by the Hospital while you are an Inpatient, including the use of operating and recovery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, radiation therapy, speech therapy and occupational therapy are also covered.
   - Convenience items (such as radios, TV's, record and CD players, telephone, visitors' meals, etc.) are not covered.
3. Length of Stay is determined by Medical Necessity.



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## 4.6 Non-Network Hospital Benefits

If you are confined in a Non-Network Hospital, your benefits will be significantly reduced, as explained in the "How Your Benefits Work For You" section.

## 4.7 Outpatient Hospital Services

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

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

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

## 4.9 Telemedicine

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

The use of standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof does not constitute Telemedicine service and is not a covered benefit.

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

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

The amount of payment for the professional service provided via Telemedicine by the Physician or practitioner at the distant site is based on the current Eligible Charges for the service provided. The patient (Member) is subject to the applicable Deductible and Coinsurance based upon their In-network or Out-of-Network benefits.

## 4.10 Outpatient Diagnostic Services

See the **Summary of Benefits** for applicable Coinsurance that may apply.

The following are examples of outpatient diagnostic services:

- All MRIs (Magnetic Resonance Imaging)
- All scans including Computerized Tomography and Positron emission Tomography
- Electromyogram
- All scope procedures including endoscopy and colonoscopy
- Myelography
- Cardiac Catheterization

(This list is subject to change.)

**Outpatient Pre-Certification Requirements**



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

Such services include, but are not limited to, outpatient surgical procedures, diagnostic imaging procedures, laboratory services, pathology services and durable medical equipment. This list is subject to change. Please call Customer Service at the number on your ID card to determine if a particular procedure requires pre-certification.

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

## 4.11 Other Covered Services

This Contract provides Covered Services when the following services are Medically Necessary. Payment terms apply to these benefits. This article describes other medial care services covered by your Contract.

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

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

1. Medical and Surgical Care

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

2. Assistant Surgery

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

3. Registered Nurse First Assistant

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

4. Treatment of Accidental Injury in a Physician's Office

   All outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician office Copayment or Deductible and Coinsurance requirements, whether by a Network or by a Non-Network Provider.

5. Non-Network Freestanding Ambulatory Facility

   Any services rendered or supplies provided while you are a patient or receive services at or from a Non-Network Freestanding Ambulatory Facility will be payable at the percentage of Eligible Charges as stated in your **Summary of Benefits**.

6. Second Medical Opinion

   Covered Services include a second medical opinion with respect to any proposed surgical intervention, or any medical care that is a Covered Service.

7. Reconstructive Surgery

   Reconstructive surgery is covered only to the extent Medically Necessary



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

8. Breast Cancer Patient Care

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

9. Breast Reconstructive Surgery

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

10. Ovarian Cancer Surveillance Tests

    a. Covered Services are provided for at risk women 35 years of age and older. At risk women are defined as: (a) having a family history (i) with one or more first or second-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, (iii) of nonpolysis colorectal cancer; or (b) testing positive for BRCA1 or BRCA2 mutations.
    b. Surveillance test means annual screening using: (a) CA-125 serum tumor marker testing, (b) transvaginal ultrasound, and (c) pelvic examinations.

11. Oral Surgery

    Pre-certification is required. Covered Services include only the following:

    - Fracture of facial bones;
    - Lesions of the mouth, lip, or tongue which require a pathological examination;
    - Incision of accessory sinuses, mouth salivary glands or ducts;
    - Dislocations of the jaw;
    - Removal of impacted teeth and associated hospitalization, but only if precertified by BCBSHP;
    - Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Benefits are not provided for fixed or removable appliances which involve movement or repositioning of the teeth (braces), or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures). TMJ is subject to a Lifetime Maximum per Member as stated in the **Summary of Benefits**;
    - Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that will lead to functional impairments. Such a requirement will not prejudice an existing claim; and
    - Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to the teeth or structure occurring while a Member is covered by this Contract and performed within 180 days after the accident.

12. Private Duty Nursing Services

    a. Inpatient private duty nursing care is covered only when no intensive or cardiac care unit is available, and the care needed is beyond the capabilities of the Hospital's floor nurses. Services may be performed by either a Network or Non-Network Provider.
    b. Certification of Medical Necessity is required from the Physician and must be confirmed by BCBSHP.
    c. Limitations for both Inpatient and Outpatient RN and LPN

       Private duty nursing services of an RN or LPN, whether on an Inpatient or Outpatient basis, are limited as shown in the **Summary of Benefits**.
    d. Eligible Charges do not include services when:



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- requested by, or for the convenience of, the patient or the patient's family;
- services consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving oral medication, or acting as a companion or sitter;
- the private duty nurse is a relative by blood or marriage or member of the household of the Member;
- Inpatient services could have been rendered by the Hospital's general nursing staff; or
- Outpatient services could be safely rendered by an individual other than a RN or LPN.

13. Use of Operating and Treatment Rooms and Equipment
14. Medical Treatment of Attention Deficit Disorder – Drugs may be prescribed by your Physician. Only legend Prescription Drugs will be covered.
15. Diagnostic x-ray and Laboratory Procedures
16. Chemotherapy and Radioisotope, Radiation and Nuclear Medicine Therapy
17. Oxygen, Blood and Components, and Administration
18. Dressings, Splints, Casts When Provided by a Covered Physician
19. Pacemakers and Electrodes
20. Dialysis Treatment

    Dialysis treatment is covered for care when pre-certification has been obtained from BCBSHP. The Contract will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.
21. Medically Necessary emergency care in a foreign country. Please see Article 7.17 for specific requirements.
22. Clinical Trial Programs for Treatment of Children's Cancer

    Covered Services include routine patient care cost incurred in connection with the provision of goods, services, and benefits to Dependent Children in connection with approved clinical trial programs for the treatment of children's cancer. Routine patient care cost means those pre-certified as Medically Necessary as provided in Georgia law (OCGA 33-24-59.1).
23. Colorectal Cancer Examinations and Laboratory Tests
    Covered Services include colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening. Benefits shall be provided for Members who are 50 years of age or older, and less than 50 years of age and at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society.
24. Diabetes

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

    Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Members meeting BCBSHP criteria.
26. Prescription Drugs
    Your benefit design as shown in the **Summary of Benefits** will determine the Copayment or Coinsurance of your Prescription Drug program for preferred formulary drugs and non-preferred drugs that are listed on the Drug Formulary as well as non-formulary drugs.

    At the time the prescription is dispensed, present your Identification Card at the Participating Pharmacy. The Participating Pharmacist will complete and submit the claim for you. If you do not go to a participating pharmacy, you may need to submit the itemized bill to be processed.



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Benefits
The Prescription Drug Program provides coverage for drugs which, under federal law, may only be dispensed with a prescription written by a Physician. Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug benefit when accompanied by a prescription.

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

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

You must have used 75% of your prescription before it can be refilled. Your Prescription Drug program uses a "refill-too-soon" computer edit as a protective measure to promote safe usage and prevent costly stockpiling of medications.

Covered Services may include:

Retail prescription medications that have been prescribed by a Network Provider and obtained through a participating pharmacy. Retail Prescription Drugs shall, in all cases, be dispensed according to the Drug Formulary for prescriptions written and filled in and out of network. Only those Prescription Drugs included in the Drug Formulary, as amended from time to time by BCBSHP, may be Covered Services, except as noted below or otherwise provided in the Drug Formulary.

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

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

To order refills, you must have used 75% of your prescription. Mail the refill notice and the appropriate Copayment or Coinsurance amount.

**Specialty Drugs**
Specialty Drugs are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Specialty Drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at retail pharmacies. Most Specialty Drugs require preauthorization. You may obtain the list of Specialty Drugs and contracted Network Specialty Pharmacies by contacting customer service or online at www.bcbsga.com.

You or your Physician may order your Specialty Drugs from a Network Specialty Pharmacy. The first time a Specialty Drug is ordered for home use you will be asked to complete a Patient Profile questionnaire. To obtain a Specialty Drug for home use, you must have a prescription for the drug which is signed by a physician and which states the drug name, dosage, directions for use, quantity, the physician's name and phone number, and the patient's name and address. If the Specialty Drug is ordered via telephone, any **C**opayment or Coinsurance due can be paid by credit card or debit card. When submitting a paper prescription, a completed order form is required along with your Coinsurance or **C**opayment payable by check, money order, credit or debit card.

Network Specialty Pharmacies will deliver your Specialty Drug prescriptions via common overnight carrier and are shipped directly to you or, if necessary, to a Network Provider for administration. Your treatment plan and specific prescription will determine where administration of the drug will occur and by whom. In order to better support your treatment plan, Specialty Drug prescriptions that exceed 30 days



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may be dispensed in more than one shipment. When this occurs, please note that your total cost for multiple shipments will not exceed the amount you would have incurred for a single shipment.

Additionally, your **C**opayment and/or Coinsurance may be prorated to support the method of distribution and treatment. If a Network Provider charges an administration fee for Specialty Drugs, that amount would be separate from the cost of the medication. Charges for drug administration are considered medical services which are subject to the **C**opayment, Coinsurance and percentage payable provisions as explained in the **Summary of Benefits**.

The Specialty Pharmacy provides dedicated patient care coordinators to help You manage Your condition and provides toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications. You or Your doctor can order your Specialty Drug direct from the specialty pharmacy by simply calling 800-870-6419. You will be assigned a patient care coordinator who will work with You and Your physician to obtain prior authorization and to coordinate the shipping of your medication directly to You or Your physician's office. Your patient care coordinator will also contact You directly when it is time to refill your prescription.

Please note that Specialty Drugs may also be obtained from an out-of-network Specialty Pharmacy that agrees to accept the same payment terms as a contracted Network Specialty Pharmacy.

**Tier Assignment Process**
We have established a National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determination of tiers is made by Us based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternative; and where appropriate, certain clinical economic factors.

We retain the right at Our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

**First-tier, second-tier, third-tier, and fourth-tier drugs**
Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by us as a first, or second, or third, or fourth "tier" Drug. The determination of tiers is made by us based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

Refer to your **Summary of benefits** to determine your Copayment, Coinsurance and Deductible (if any) amounts. Prescription drugs will always be dispensed as ordered by your Physician. You may request, or your Physician my order, the Brand Name Drug. However, if a Generic Drug is available, you will be responsible for the difference in the allowable charge between the Generic and Brand Name Drug, in addition to your brand Copayment. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.



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**Tier 1** Prescription Drugs have the lowest Coinsurance or Copayment. This tier will contain low cost and preferred medications that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

**Tier 2** Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This tier will contain preferred medications that may be Generic, single source, or multi-source Brand Drugs.

**Tier 3** Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This tier will contain non-preferred and high cost medications. This will include medications considered Generic, single source brands, and multi-source brands.

**Tier 4** Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier will contain Specialty Medications which include at least two (2) of, but not limited to the following:

1. The Prescription Drug is approved to treat limited patient populations with complex and/or chronic medical conditions.
2. The Prescription Drug requires complex care.
   - Requires frequent dosing adjustments and clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes.
   - Requires clinical support to maximize a patient's outcome (i.e., needs patient training and compliance assistance to facilitate therapeutic goals).
3. The Prescription Drug is a therapeutic biological product (i.e. Monoclonal antibody, Cytokine, growth factor, enzyme, non-vaccine therapeutic immunotherapy or miscellaneous recombinant therapy).
4. The Prescription Drug is available through limited distribution (i.e., is available through limited number of pharmacies).
5. The Legend Drug has an orphan drug status (drug funded by the government for a rare condition).

**Drug Formulary**
A Member or prospective Member shall be entitled upon request, to a copy of the Drug Formulary Guide, available through the Member Guide, our website (www.bcbsga.com) or as a separate reprint.

BCBSHP may only modify the Drug Formulary for the following reasons:

- Additions of new drugs, including generics, as they become available.
- Removal of drugs from the marketplace based on either FDA guidance or the manufacturer's decision.
- Re-classification of drugs from formulary preferred to formulary non-preferred or vice versa. All drug reclassifications are overseen by an independent Physician review committee. Changes can occur:
  - Based on new clinical studies indicating additional or new evidence that can either benefit the patient's outcome or that identifies potential harm to the patient.
  - When multiple Similar Drugs are available such as other drugs within a specific drug class (for example anti-inflammatory drugs, anti-depressants or corticosteroid asthma inhalers;
  - When a Brand Name Drug loses its patent and generics become available; or
  - When Brand Name Drugs become available over the counter.
- Re-classification of drugs to non-formulary status when Therapeutic/Clinically Equivalent drugs are available including over the counter drugs.

Similar Drugs mean drugs within the same drug class or type. Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

You will be notified in writing of drugs changing to non-formulary status at least 30 days prior to the Effective Date of the change if you have had a prescription for the drug within the previous 12 months of coverage under this plan. Drugs considered for non-formulary status are only those with Therapeutic/Clinically Equivalent alternatives.



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You may use the prior authorization process to request a non-formulary drug. If your prior approval request is denied, you may exercise your right to appeal. For information regarding either the prior authorization or appeals process, please call the customer service number on your Identification Card. Georgia law allows You to obtain, without penalty and in a timely fashion, specific drugs and medications not included in the Drug Formulary when:

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

**Special Pharmacy Programs**

From time to time we may initiate various programs to encourage Members to utilize more cost-effective or clinically-effective drugs including, but not limited to, Generic Drugs, mail order drugs, over-the-counter items (OTC), or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or preferred products for a limited period of time.

**Voluntary Half-Tablet Program**

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

**Off-Label Drugs**

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

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

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

Your benefit design, as shown in the **Summary of Benefits**, will determine the Copayment or Coinsurance of your prescription drug program for preferred Formulary drugs and non-preferred drugs that are listed on the Drug Formulary, as well as non-formulary drugs. Covered prescription inhalants will not be subject to a day limit.

The following are not Covered Services under this Contract:

- Prescription drug products for any amount dispensed which exceeds the FDA clinically recommended dosing schedule.
- Prescription Drugs received through an Internet pharmacy provider or mail order provider except for our designated mail order provider.
- Non-legend vitamins.
- Smoking cessation products (including the use of Wellbutrin SR for this purpose).
- Over-the-counter items.
- Cosmetic drugs (i.e., Propecia).
- Appetite suppressants (Anorexiants).
- Weight loss products.
- Diet supplements.
- Syringes (for use other than insulin) except when in coordination with an approved injectable.
- Non-contraceptive injectables (except with pre-certification).



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- The administration or injection of any Prescription Drug or any drugs or medicines.
- Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued.
- Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order.
- Prescription Drugs for which there is no charge.
- Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use.
- Prescription Drugs for use as an Inpatient or outpatient of a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients.
- Charges for delivery of any Prescription Drugs.
- Drugs and medicines which do not require a prescription order and which are not Prescription Drugs (except insulin).
- Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs.
- Prescription Drugs which are not Medically Necessary or which we determine are not consistent with the diagnosis.
- Prescription Drugs which we determine are not provided in accordance with accepted professional medical standards in the United States.
- Any services or supplies, which are not specifically listed as covered under this Prescription Drug program.
- Prescription Drugs which are Experimental or Investigational in nature as explained in the "Limitations and Exclusions" section.
- Vaccines delivered by nasal spray or mist
- Prescription medicine for nail fungus except for immunocompromised or diabetic patients.
- Non-formulary drugs except as described in this Prescription Drug Program section.

27. Nutritional Counseling

    Related to medical management of a disease state (subject to pre-certification by BCBSHP).
28. Cardiac Rehabilitation -- Programs require pre-certification by BCBSHP and Individual Case Management.
29. Pulmonary Rehabilitation – Programs require pre-certification by BCBSHP and Individual Case Management.
30. Durable Medical Equipment
    a. This contract will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable pre-certification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician.
    b. The equipment must meet the following criteria:
        - It can stand repeated use;
        - It is manufactured solely to serve a medical purpose;
        - It is not merely for comfort or convenience;
        - It is normally not useful to a person not ill or injured;
        - It is ordered by a Physician,
        - The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. BCBSHP may require proof of the ongoing Medical Necessity of any item; and it is related to the patient's physical disorder.

    Wheelchairs must also meet the following criteria:



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

31. Ambulance Service
    a. Local service to the nearest appropriate facility in connection with care for Medical Emergency or if otherwise Medically Necessary. Such service also covers your transfer from one Hospital to another Hospital if Medically Necessary.
    b. Air ambulance to the nearest appropriate facility is covered subject to Medical Necessity.
32. Prosthetic Appliances

    Prosthetic devices to improve or correct conditions resulting from an Accidental Injury or illness are covered if Medically Necessary. Prosthetic devices include cranial prosthetics, artificial limbs and accessories; artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes), and external breast prostheses used after breast removal.
33. Hospital Visits
    a. The Physician's visits to his or her patient in the Hospital are Covered Services.
    b. Covered Services are limited to one daily visit for each Physician during the covered period of confinement.
34. Consultation Services
    a. Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury.
    b. Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Contract.
35. General Anesthesia Services
    a. Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.
    b. Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling or loss of consciousness:
       - Spinal or regional anesthesia;
       - Injection or inhalation of a drug or other agent (local infiltration is excluded).
    c. Anesthesia administered by a Certified Registered Nurse anesthetist (CRNA) is also covered.
    d. Anesthesia services will not be paid if they are rendered in conjunction with surgical or other care which are Non-Covered Services.
36. Anesthesia Services for Certain Dental Patients

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

    Services within the lawful scope of practice of and rendered personally by a licensed optometrist (O.D.), for which payment would be made under this Contract to a Physician providing the same services.
38. Physical Therapy/Occupational Therapy, Chiropractic Care or Services of Athletic Trainers

    Services by a Physician, a registered physical therapist (RPT), a licensed occupational therapist (O.T.), a licensed chiropractor (D.C.), or qualified athletic trainers are limited to a combined total maximum



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visits per calendar year as outlined in the **Summary of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

39. Licensed Speech Therapist Services

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

40. Outpatient Surgery

41. Network Hospital outpatient department or Ambulatory Surgery Center charges are covered at regular Contract benefits as stated in the **Summary of Benefits**. Complications of Pregnancy

We cover Complications of Pregnancy. Complications of Pregnancy include conditions that would be considered life threatening to the mother. A life-threatening condition would be a condition of sufficient severity that the absence of immediate medical attention could be reasonable expected to result in a treat to life (immediate or delayed). Complications of Pregnancy include conditions where the diagnosis is distinct from the pregnancy, and are caused by or adversely affected by the pregnancy. Complications of Pregnancy do not include the actual delivery of the baby except in cases of life-threatening hemorrhage to the mother.

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

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

We also cover under this benefit:

- Termination of pregnancy for fetal demise or severe, profound deformity or disease if the pregnancy did not begin before the Effective Date of the Contract.

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

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

**IMPORTANT:** This particular limitation does not apply to you if you served your Waiting Period or received 12 months of credit towards your Waiting Period at the time you first enrolled under this Contract.



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42. Skilled Nursing Facility Care
    a. Benefits are provided as outlined in the **Summary of Benefits**. Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Skilled care during a period of recovery is characterized by:
        - A favorable prognosis;
        - A reasonably predictable recovery time; and
        - Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the patient's residence.
    b. Covered Services include:
        - Semiprivate Room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Contract pays the amount of the Semiprivate Room rate toward the charge for the private room;
        - Use of special care rooms;
        - Pathology and radiology;
        - Physical or speech therapy;
        - Oxygen and other gas therapy;
        - Drugs and solutions used while a patient; and
        - Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages and casts.
    c. This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.
    d. Benefits will not be provided when:
        - A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
        - Care is primarily Custodial, not requiring definitive medical or 24-hour-a-day nursing service;
        - Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
        - A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care; or
        - The care rendered is for other than Skilled Convalescent Care.
43. Home Health Care services
    a. Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Summary of Benefits**. A visit consists of up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Non-Network Providers.
    b. Some special conditions apply:
        - The Physician's statement and recommended program must be pre-certified.
        - Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis.
        - A Member must be essentially confined at home.
    c. Covered Services:
        - Visits by an R.N. or L.P.N. Benefits cannot be provided for services if the nurse is related to the Member.
        - Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.



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- Visits to render services and/or supplies of a licensed medical social services worker when Medically Necessary to enable the Member to understand the emotional, social, and environment factors resulting from or affecting the Member's illness.
- Visits by a home health nursing aide when rendered under the direct supervision of an R.N.
- Administration of prescribed drugs.
- Oxygen and its administration.

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

d. Home Health Care benefits Shall not be Provided for:
   - Food, housing, homemaker services, sitter and home-delivered meals
   - Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
   - Services and/or supplies which are not included in the Home Health Care program as described.
   - Services of a person who ordinarily resides in the patient's home or is a member of the family or either the patient or patient's spouse.
   - Any services for any period during which the Member is not under the continuing care of a Physician.
   - Services or supplies for mental health conditions, including alcohol and drug abuse.
   - Private duty nursing.

44. Hospice Care Services

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

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

    To qualify for Hospice care, the attending Physician must certify that the patient is not expected to live more than six months. Also, the Physician must design and recommend a Hospice Care Program. The Physician's statement and recommended program must be pre-authorized.

45. Individual Case Management

    a. The Individual Case Management program is designed to ensure and provide payment of benefits to eligible Members who, with their attending Physician, agree to treatment under an alternative benefit plan intended to provide quality health care under lower cost alternatives. Such benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each program participant. The program includes:
       - The identification of potential program participants through active case finding and referral mechanisms;
       - Eligibility screening;
       - Preparation of alternative benefit plans; and



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- Subsequent to the approval of the parties, transfer to alternative treatment settings in which quality care will be provided.

b. Eligibility

A Member receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Contract benefits. BCBSHP is responsible for determining eligibility for cases to be included in the program.

The Member, or legal guardian or family, if applicable, and the attending Physician must consent to explore with BCBSHP the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

c. Benefits

Benefits will be determined on a case-specific basis. Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is less expensive than the original treatment plan which otherwise would have been followed. BCBSHP will determine the maximum approved payments allowable under the program. In a given benefit period, the total approved payment limit will not exceed the dollar value of the remaining Hospital Inpatient days under the Member's contract.

Benefits under the program are furnished as an alternative to other Contract benefits and are limited to the following:

- Services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Member.
- Non-structural modifications to the home which are required to meet minimum standards for safe operation of equipment.
- When necessary for the long-term care of the Member in the home setting, Respite Care to relieve family members or other persons caring for the Member at home. (The Respite Care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to six consecutive days at a time. BCBSHP may approve on an exception basis up to 5 days per month or Respite Care when medical review of the case indicates that such action is appropriate. Payments for Respite Care will be deducted from the Member's remaining available benefits under the Individual Case Management Program.)

The Member must obtain pre-certification from BCBSHP regarding the treatment plan and proposed setting to be utilized during the respite period. Potential cases include but are not limited to:

- Spinal cord Injury;
- Severe head trauma/coma;
- Respiratory dependence;
- Degenerative muscular/neurological disorders;
- Long-term IV antibiotics;
- Premature birth;
- Burns;
- Cardiovascular accident;
- Cancer;
- Accidents;
- Terminal illness; or
- Other cases at BCBSHP's discretion.

d. Covered Services



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Services covered under Individual Case Management will be determined by BCBSHP at its sole discretion, on a case-by-case basis. Benefits may be provided for the rehabilitation of a Member on an Inpatient, outpatient, or out-of-hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.

The program may provide or coordinate any of the types of Covered Services provided pursuant to this Contract.

At its sole discretion, in the context of an Individual Case management program, BCBSHP may also provide or arrange for alternative services or extra-contractual benefits which are either (i) excluded by this Contract; (ii) neither excluded nor defined as Covered Services under this Contract; or (iii) exceeding the maximum for any Covered Service under this Contract.

e. Utilization

Benefits will be provided only when and for as long as BCBSHP deems they are Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long, and shall be subject to Pre-certification and continuing review for Medical Necessity as set forth in such plan of treatment.

The total benefits that may be paid will not exceed those which the Member would otherwise have received in the absence of Individual Case Management benefits.

f. Exclusions

Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in BCBSHP's sole discretion, significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the Individual Case Management program.

g. Individual Case Management Definitions:

Case Manager
The person designated by BCBSHP to manage and coordinate the Member's medical benefits under the Individual Case Management program. The Case Manager's role is determined by BCBSHP.

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

h. Termination of Individual Case Management

Services in the alternative benefit plan approved by BCBSHP under Individual Case Management will cease to be covered benefits under this Contract when:

- Extra-contractual benefits or alternative services are no longer required due to a change in the patient's condition; or
- The total amount of benefits paid for such services and for all other Covered Services equals the Lifetime Maximum Benefit.

46. Organ/Tissue/Bone Marrow Transplants

a. Covered Services include certain services and supplies not otherwise excluded in this Contract and rendered with covered transplant, including pre-transplant procedures such as organ harvesting (donor costs), post-operative care (including anti-rejection drug treatment) and transplant-related chemotherapy for cancer limited as follows.

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

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



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c. **A covered transplant means a medically appropriate transplant of one or more of the following organs or tissues only and no others:**
   - Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas, or kidney and pancreas when transplanted together in the same operative session.
   - Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, but only if required in the treatment of:
     - Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
     - Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
     - Neuroblastoma, Stage III or Stage IV;
     - Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have an HLA-compatible donor available for allogenic bone marrow support;
     - Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds;
     - Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
     - Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in complete or partial remission, or those in a responsive relapse;
   - Homogenic/allogenic (other-donor) or syngenic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:
     - Aplastic anemia;
     - Acute leukemia;
     - Severe combined immunodeficiency exclusive of acquired immune deficiency syndrome (AIDS);
     - Infantile malignant osteoporosis,
     - Chronic myelogenous leukemia;
     - Lymphoma (Wiscott-Aldrich syndrome);
     - Lysosomal storage disorder;
     - Myelodysplastic syndrome.

d. Definitions
   - "Donor costs" means all costs, direct and indirect (including program administration costs), incurred in connection with:
     - medical services required to remove the organ or tissue from either the donor's or the self-donor's body,
     - preserving it; and
     - transporting it to the site where the transplant is performed.
   - In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports. For purposes of this benefit, the term "transplant" does not include transplant of blood or blood derivatives (except hematopoietic stem cells) which will be considered as nontransplant related under the terms of this Contract.
   - "Facility transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and antirejection drugs.
   - "Medically appropriate" means the recipient or self-donor meets the criteria for a transplant established by BCBSHP.



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- "Professional provider-transplant services" means all Medically Necessary services and supplies provided by a professional provider in connection with a covered transplant except donor costs and antirejection drugs.

e. Benefits for Antirejection Drugs

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

f. Pre-Certification Requirement

All transplant procedures must be pre-certified for type of transplant and be Medically Necessary and not Experimental or Investigational according to criteria established by BCBSHP. To pre-certify, call the BCBSHP office using the telephone number on your Identification Card.

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

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

If the transplant involves a living donor, benefits are as follows:

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

**Please see the "Limitations and Exclusions" section for Non-Covered Services.**

47. Dental Services for Accidental Injury

We cover the cost of dental services and dental appliances only when required to diagnose or treat an Accidental Injury to the teeth which occurred on or after your Effective Date. Services must occur within 180 days of the date of accident.

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

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

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

48. Dental Services

Covered services include Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Benefits are not provided for fixed or removable appliances which involve movement or repositioning of



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the teeth (braces), or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures). TMJ is subject to a Lifetime Maximum per Member as stated in the **Summary of Benefits**.

- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that will lead to functional impairments. Such a requirement will not prejudice an existing claim; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to the teeth or structure occurring while a Member is covered by this Contract and performed within 180 days after the accident.

Anesthesia Services for certain dental patients' general anesthesia and associated Hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:

- Patients age 7 or younger who are developmentally disabled.
- An individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder.
- An individual who has sustained extensive facial or dental trauma, except for a Workers' Compensation claim.

Pre-certification is required.

49. Newborn Services

In addition to the services described in this article, we cover:

- Medically Necessary care and Treatment of medically diagnosed congenial defects and birth abnormalities for covered newborns; and
- Inpatient and outpatient dental, oral surgical and orthodontic services which are Medically Necessary for the Treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia for covered newborns.

## 4.12 Mental Health Care and Substance Abuse Treatment

**Substance Abuse Treatment Facility Services**

When you are an Inpatient at a Substance Abuse treatment facility, your Covered Services are the same as Inpatient Hospital services listed under the Inpatient Hospital Services provision in this article as long as:

- the service is provided to diagnose or treat alcohol and/or drug abuse; and
- the service is of a type that a Substance Abuse treatment facility is normally equipped to provide.

Your **Summary of Benefits** provides the dollar or visit limitations for this benefit.

**Mental Health Services**

We cover the following mental health services:

**Inpatient Facility Mental Health Services**

We cover mental health services provided to you as an Inpatient by a Hospital or Substance Abuse treatment facility. These services are described in detail under the Inpatient Hospital Services provision in this article and under the Substance Abuse Treatment Facility Services provision found above.

**Inpatient Professional Mental Health Services**

We cover appropriate Physician attention to you while you are an Inpatient in a Hospital or Substance Abuse treatment facility. We call the charges for your Physician's services in this context Inpatient professional mental health service charges. These charges are different from Inpatient facility mental health service charges because you may be in the Hospital, but not need any Physician attention on a certain day. You would be billed under Inpatient facility mental health services only. You should not be charged for any Inpatient professional mental health services.



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Please note that Inpatient services for Substance Abuse treatment must not be merely custodial, residential, or domiciliary in nature and must be provided in a Hospital or Substance Abuse treatment facility which is licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation, including 24-hour-a-day nursing care**.**

**LIMITATION:** You have a limited number of days per Benefit Period for Inpatient professional mental health services and for Inpatient facility mental health services. As you must be admitted to a Hospital or Substance Abuse treatment facility to get either or both of these services, once you have used up your limited number of days for Inpatient facility mental health services, we will not cover any more Inpatient professional mental health services, even if you have used less than the specified number of days of Inpatient professional mental health services, for the remainder of the Benefit Period. See your **Summary of Benefits** for day limitations.

**Mental Health Services - Office/Outpatient**
We cover outpatient mental health services for a mental condition or for Substance Abuse (including care related to alcohol and/or drug addiction) as listed below.

This Contract covers outpatient mental health services for:

- individual psychotherapy;
- group psychotherapy;
- psychological testing;
- family counseling. Family counseling involves two or more family members to promote understanding of the patient and more acceptable ways of family functioning. It is not Treatment for the other family members; and
- convulsive therapy Treatment (electroshock or convulsive drug therapy), including anesthesia when administered with other Treatments by the same Provider.

The following services are not considered to be Medically Necessary and will not be covered under any circumstances:

- more than two hours of psychotherapy during a 24 hour period;
- group psychotherapy when there are more than eight patients with a single therapist;
- group psychotherapy when there are more than twelve patients with two therapists; and
- more than twelve convulsive therapy Treatments during a single admission.

Outpatient mental health visit limits do not include medication management visits. Refer to the Mental Health Services - Office/Outpatient provision above.

**LIMITATION:** This Contract limits the number of outpatient Provider visits per Benefit Period for covered mental health services. Once you have used your maximum number of visits per Benefit Period, this Contract will not cover any more outpatient mental health care for the remainder of the Benefit Period. Please see your **Summary of Benefits** for the visit limitations of this benefit.

This policy excludes all Treatment for the following behavioral/social conditions:

- anti-social personality;
- inadequate personality;
- sexual deviation;
- social maladjustment without apparent mental health disorder;
- group delinquent reaction of childhood;
- conduct disorders; and
- oppositional disorders.

This Contract excludes the following forms of Treatment:

- services directed toward making one's personality more forceful or dynamic;



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- consciousness raising;
- vocational or religious counseling;
- group socialization;
- activities primarily of an educational nature;
- Inpatient stays for environmental changes;
- outpatient marital counseling;
- cognitive rehabilitation therapy;
- educational therapy;
- vocational and recreational therapy. Recreational therapy includes (but is not limited to) sleep, dance, art, crafts, aquatic, hydro, gambling and nature therapy;
- coma stimulation therapy;
- services to treat sexual deviation and dysfunction, including services for or related to sex transformation when the dysfunction is not related to organic disease;
- self-help, training, and self-administered services, including biofeedback and related testing;
- services related to smoking cessation, such as stop smoking aids or services of stop smoking clinics;
- behavioral modification; and
- modalities which include: primal therapy; rolfing or structural integration; bioenergetic therapy; carbon dioxide therapy; guided imagery; Z-therapy; obesity control therapy; training analysis; sleep therapy; sedac therapy; dance therapy; music therapy; and art therapy.

**IMPORTANT:** If a covered person has a behavioral/social problem that is manifested from a mental illness, the Treatment for the mental illness is covered, not the Treatment for the behavioral/social problem.



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# 5. Limitations and Exclusions

## 5.1 Pre-existing Conditions

We do not cover services you receive during the first 12 months after your Effective Date for pre-existing conditions. "Pre-existing condition" means a condition which manifests itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or Treatment within 12 months immediately preceding his or her Effective Date. Pre-existing condition also means a condition for which medical advice, diagnosis, care or Treatment was recommended or received within 12 months immediately preceding his or her Effective Date. A pregnancy existing on the Effective Date is also a pre-existing condition.

**Credit Towards Waiting Period for Pre-existing Conditions**

Upon issue of this Contract, you may have received credit toward the 12 month Waiting Period for pre-existing conditions because of the circumstances of your previous health coverage. For you to have received this credit, your prior health insurance coverage must have been an individual or group policy providing Hospital coverage, medical and surgical coverage, or major medical coverage on an expense-incurred basis. Your prior coverage must have been continuous to a date no more than 63 days before your Effective Date of this policy. Even though you may be eligible for credit towards your Waiting Period, no credit will be given toward your Deductible or Out-of-Pocket Limit. You will receive credit toward the Waiting Period for pre-existing conditions if you were insured under our Short Term Contract as long as there is no more than a 63-day break in coverage before your Effective Date under this Contract.

## 5.2 Excess Coverage Provision

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

## 5.3 Governmental Programs

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

## 5.4 Exclusions

**Your Contract does not provide benefits for:**

1. Services for **pregnancy-related conditions,** except complications of pregnancy as described in this policy. Examples of pregnancy-related conditions include:
   - childbirth;
   - termination of pregnancy, except as described in the complications of pregnancy provision;
   - elective or non-elective cesarean sections;
   - pre-natal and post-natal care;
   - delivery room use;
   - hospital bed and board for mother and newborn;
   - certain routine newborn screenings and certain routine newborn physician services rendered in a newborn nursery, except as provided in the preventive acre and immunization provision;
   - routine newborn nursery supplies;
   - routine circumcision of a newborn male;
   - diagnostic laboratory and x-rays; or
   - maternity-related services.
2. Care, supplies or equipment not Medically Necessary, as determined by BCBSHP, for the treatment of an Injury or illness.
3. Any item, service, supply or care not specifically listed as a Covered Service in this Contract.



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4. Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends. (Such a requirement shall not prejudice an existing claim.) Such services and supplies shall include, but not be limited to, Inpatient Hospital Admissions which begin before a Member's Effective Date.
5. Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
6. Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
7. Any portion of a provider's fee or charge which is ordinarily due from a Member but which has been waived. If a provider routinely waives (does not require the Member to pay) a Deductible or Out-of-Pocket amount, BCBSHP will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
8. Care for any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self-insurance association because of the Injury or disease.
9. Any disease or injury resulting from a war, declared or not, or any military duty, or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities as required by law.
10. Care given by a medical department or clinic run by your employer.
11. Admission or continued Hospital or skilled nursing facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
12. Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
13. Preventative care of corns, bunions (except capsular or related surgery), calluses, toenails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
14. Daily room charges while the Contract is paying for an intensive care, cardiac care, or other special care unit.
15. Vision care services and supplies not specifically listed as covered, including but not limited to eyeglasses, contact lenses and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service.
16. Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Contract. We do not cover vaccinations, immunizations or other injections not used to treat a current illness except as provided under the Child Wellness Services or Preventive Services.
17. The following items related to Durable Medical Equipment:
    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Arch supports, orthopedic or corrective shoes;
    - Heating pads, hot water bottles, home enema equipment or rubber gloves;
    - Sterile water;
    - Deluxe equipment, such as motor driven chairs or beds, when standard equipment is adequate;
    - Rental or purchase of equipment if you are in a facility which provides such equipment;
    - Electric stair chairs or elevator chairs;
    - Physical fitness, exercise, or ultraviolet/tanning equipment;
    - Residential structural modification to facilitate the use of equipment;
    - Other items of equipment which BCBSHP feels do not meet the listed criteria.
18. The following items related to prosthetic devices: corrective shoes; dentures, replacing teeth or structures directly supporting teeth, except to correct traumatic injuries, electrical or magnetic continence aids, either anal or urethral; hearing aids or hearing devices; implants for cosmetic purpose except for reconstruction following mastectomy.



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19. Custodial care, domiciliary care, residential care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.
20. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
21. Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
22. Care, supplies or equipment not Medically Necessary for the treatment of Injury or illness. Non-covered supplies are inclusive of but not limited to: band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business, and adjustments made to vehicles.
23. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regiments or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary be BCBSHP, are not covered.
    - This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions including but not limited to, cleft lip and cleft palate.
    - The following criteria must be met to qualify for breast reduction surgery: The affected area must be more than 250 grams over the normative average.
    - This exclusion does not apply to Breast Reconstruction Surgery. Please see the "Benefits" section of this Contract.
24. Complications of Non-Covered procedures are not covered.
25. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties, dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this Contract.
26. Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care providers as listed in this Contract.
27. Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, surgical care, medical care or Prescription Drugs, or dietary control related to covered nutritional counseling. Nutritional and/or dietary supplements except as provided in this Contract or as required by law. This exclusion includes, but is not limited to those for nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacists; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, surgical or psychiatric care or counseling. Weight loss programs, nutritional supplements, or psychiatric care or counseling. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes, but is not



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limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs;nutritional supplements, appetite suppressants, and supplies of a similar nature. Procedures including but not limited to liposuction, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, and wiring of the jaw.

28. Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).
29. Transportation provided by other than a state licensed Professional Ambulance Service, and ambulance service other than in a Medical Emergency.
30. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
31. Advice or consultation given by any form of telecommunication.
32. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in BCBSHP's judgment Experimental or Investigational for the diagnosis for which the Member being treated. An Experimental or Investigation service is not made eligible for coverage by thee fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service prescribed as the most likely to prolong life.
33. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
34. Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.
35. Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
36. Services for outpatient therapy or rehabilitation other than those specifically listed in this Contract. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide.
37. Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
38. Treatment where payment is made by any local, state or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, Veterans Administration (VA) Hospitals, school speech and reading programs.
39. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Member has enrolled in Medicare Part B
40. Expenses in excess of the Usual, Customary, and Reasonable (UCR) Fees (as determined by BCBSHP).
41. Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reversal of voluntarily induced sterility, or combination thereof.
42. Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
43. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rental, homemaker services, travel expenses, and take-home supplies.
44. Inpatient Hospital care for mental health conditions when the stay is:
    - determined to be court-ordered, custodial, or solely for the purpose of environment control;
    - rendered in a home, halfway house, school or domiciliary institution;
    - associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related to marital, social, cultural or work situations.
    - incurred through participation in day/night and/or partial hospitalization programs.



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45. Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delays, including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that we provide for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, Developmental Delay, behavioral problems, and mental retardation. Neither speech, physical nor occupational therapy is covered for Developmental Delay. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
46. Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Member is medically stable and does not require Skilled Nursing Convalescent Care or the constant availability of a Physician or:
    - the treatment is for maintenance therapy; or
    - the Member has no restorative potential; or
    - the treatment is for congenital learning or neurological disability/disorder; or
    - the treatment is for communication training, educational training or vocational training.
47. Injuries received while committing a crime.
48. Biomicroscopy, field charting or aniseikonic investigation.
49. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
50. Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.
51. Non-emergency treatment of chronic illnesses received outside the United States performed without pre-certification.
52. Any drug or other item which does not require a prescription.
53. Preventive care except as specified in this Contract.
54. The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    - Surgical or medical care related to animal organ transplants, animal tissue transplants (except for porcine heart valves), artificial organ transplants or mechanical organ transplants;
    - Transportation, travel or lodging expenses for non-donor family members;
    - Donation related services or supplies, including search, associated with organ acquisition and procurement;
    - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
    - Any transplant not specifically listed as covered.
55. Acupuncture and acupuncture therapy.
56. Private room, except as specified as specified as Covered Services.
57. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
58. Court-ordered services, or those required by court order as condition of parole or probation.
59. Hypnotherapy.
60. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
61. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
62. Specific medical reports, including those not directly related to treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
63. Thermograms and thermography.
64. Maternity Care for dependent children.
65. Elective abortion.



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66. Telehealth consultations will not be reimbursable for the use of audio only telephone, facsimile machine or electronic mail.
67. Sclerotherapy of extremity veins.
68. Midwife.
69. Hearing aids, hearing devices and related examinations and services.
70. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
71. Any services or supplies provided to any person not covered under the Contract in connection with a surrogate pregnancy (i.e. including, but not limited to, the bearing of a child by another woman for an infertile couple).



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# 6. Member Rights and Responsibilities

## 6.1 Your rights as a Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Member

**As a Member, you have the right to:**

- Recommend changes to the Member's Rights and Responsibilities policy.
- Receive information about BCBSHP, its services, its Providers, and about your Rights and Responsibilities as a Member.
- Choose your personal Physician from BCBSHP's network directory listing Network Providers and change your personal Physician.
- Receive considerate and courteous service with respect for personal privacy and human dignity through BCBSHP in a timely manner.
- Expect BCBSHP to implement policies and procedures to ensure the confidentiality of all your personal health information.
- Understand where your consent is required and you are unable to give consent, BCBSHP will seek your designated and/or guardian/representative to provide this consent.
- Participate in full discussion with your Provider concerning the diagnosis, appropriate or Medically Necessary treatment options, and the prognosis of your conditions, regardless of whether or not the information represents a covered treatment or benefit.
- Receive and be informed about where, when, and how to obtain all benefits to which you are entitled under your Contract including access to routine services, as well as after-hours and emergency services.
- Be informed of your Premiums, Deductibles, Copayments, Coinsurance, and any maximum limits on Out-of-Pocket expenses for items and services (both In-and Out-of-Network).
- Receive Contract rules regarding Copayments, Deductibles, and pre-certification including, but not limited to, pre-certification, concurrent review, post service review, or post payment review that could result in your being denied coverage of a specific service.
- Participate with providers in the decision-making process concerning your health care.
- Refuse treatment and be informed by your Physician of the medical consequences.
- Receive specific information, upon your request, from Network and Participating Providers including, but not limited to, accreditation status, accessibility of translation or interpretation services, and credentials of Providers of direct patient care) limited to contract Providers). BCBSHP encourages Network and Participating Providers to disclose such information upon Member request.
- Receive, upon request, a summary of how Physicians, Hospitals and other Providers are compensated using a variety of methodologies, including fee-or-service, per diem, discounted charges and global reimbursement.
- Express your opinions, concerns, or complaints about the coverage and the care provided by Network and Participating Providers in a constructive manner to the appropriate people within BCBSHP and be given the right to register your complaints and to appeal to BCBSHP's decisions.
- Receive, upon request a summary of the number, nature and outcome of all formally filed grievances filed with BCBSHP in the past three years.
- Receive timely access to medical records and health information maintained by BCBSHP in accordance with applicable federal and state laws.

## 6.2 Your responsibilities as a Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Member

**As a Member, you have the responsibility to:**

- Maintain your health and participate in the decisions concerning treatment.
- Ask questions and make certain that you understand the explanations and instructions you are given by your Physician, and comply with those conditions.
- Identify yourself as a Member when scheduling appointments or seeking specialty care, and pay any applicable Physician office Copayments at the time of service and Coinsurance in a timely manner.
- Keep scheduled appointments or give adequate notice of delay or cancellation.



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- Furnish information regarding other health insurance coverage.
- Treat all Network and Participating Physicians and personnel respectfully and courteously as partners in good health care.
- Permit BCBSHP to review your medical records as part of quality management initiatives in order to comply with regulatory bodies.
- Provide, to the extent possible, information that BCBSHP and its providers need, in order to care for you.
- Follow the plans and instructions for care that you have agreed on with your Physicians.



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# 7. General Provisions

## 7.1 Entire Contract and Changes

1. Your Application, this document, any later Applications, and any future attachments, additions, deletions, or other amendments will be the entire Contract. No change in this Contract is valid unless signed by the President of BCBSHP. No agent or employee of BCBSHP may change this Contract or declare any part of it invalid.
2. BCBSHP has the right to amend this Contract at any time by giving you written notice of the amendment at least 90 days before the amendment takes effect. You must agree to the change in writing. However, this requirement of notice shall not apply to amendments which provide coverage mandated by the laws of the State of Georgia.

## 7.2 Time Limit on Certain Defenses

1. BCBSHP may cancel this coverage within two (2) years from the Effective Date for any ineligible family member on whom fraudulent information has been submitted. The Member assumes liability for reimbursement to BCBSHP for any benefit payment made on behalf of such family Member.
2. Two years after this Contract is issued, no false statements which might have been in your Application can be used to void the Contract. Also, after these same two years no claim can be denied because of any false statement on your Application.
3. One year after this Contract is issued, no claim can be reduced or denied simply because you had a disease or condition prior to your Effective Date. This section does not remove the limits on services which are excluded from payment.

## 7.3 Grace Period

After you pay us the first Premium, you then have a 31-day grace period for paying us each subsequent Premium due. We keep your Contract in force during this 31-day grace period. If you do not pay us the Premium you owe by the end of the grace period, we lapse your Contract. “Lapse” means your Contract is no longer in effect. We cover valid claims incurred during the grace period. If benefits are provided for services rendered during the grace period, we have the right to collect the Premium for the grace period.

## 7.4 Reinstatement

1. If your coverage ends in any manner, you may be considered for reinstatement.
2. However, if your coverage ended because you did not make payments, coverage under a reinstatement is limited to covering Accidental Injuries from the date of reinstatement and any illness which begins 10 days after your reinstatement. Your rights in all other areas of this Contract remain the same as before the due date of the charges which you did not pay.
3. BCBSHP does not require an application for reinstatement. However, if in the future BCBSHP requires an Application for reinstatement and issues a conditional receipt for the Premium tendered, the Contract will be reinstated upon approval, upon the 45th day following the date of such conditional receipt unless BCBSHP has previously notified the insured in writing of its disapproval of such Application.

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

1. Under normal conditions a Member should file a claim within 90 days after the service was provided. Failure to file such claim within the required time will not invalidate or reduce the claim if it was not reasonably possible to file such claim.
2. All notices of claims, proofs of loss, and claim forms should be sent to the following address:

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



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

## 7.6 Balance Billing

Network and Participating Physicians are prohibited from balance billing. A Network or Participating Physician has signed an agreement with BCBSHP to accept our determination of the Usual, Customary and Reasonable Fee or Reimbursement Rate for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Contract, e.g., Copayments, Deductibles or Coinsurance.

## 7.7 Time of Payment of Claims

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, BCBSHP will notify you within 15 working days of the reason for the delay and list all information needed to continue processing your claim. After this data is received by BCBSHP, claims processing will be completed during the next 15 working days. BCBSHP shall pay interest at the rate of 18% per year to you or the assigned provider if it does not meet these requirements.

## 7.8 Physical Examinations

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

## 7.9 Legal Action

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

## 7.10 Assignment of Benefits

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

## 7.11 Unreasonable Fees

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

## 7.12 Compliance with Given Provisions

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

## 7.13 Renewability

You may renew this Contract by sending the Premium to BCBSHP by the due date. This payment renews your Contract for the period of time covered by the Premium.

## 7.14 Change in Premium Charge

1. Your Premium charge will increase based on your place of residence and your age, gender, and type of coverage. Your Premium charge may change based upon any change of residence. You will be given sixty (60) days written notice of any such change.



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

3. The Premium amount due for this Contract may change because of adding a Dependent or terminating coverage of a Dependent. Please tell us in writing as soon as any of the following happens:
   - the Subscriber and the covered spouse divorce;
   - the end of the calendar year a covered Dependent child reaches age 25;
   - a covered Dependent child marries;
   - a covered person begins active duty with the Armed Services;
   - death of the Dependent; or
   - a child is born to or adopted by the Subscriber.

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

## 7.15 Unpaid Premium

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

## 7.16 Applicable Law

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

## 7.17 Care Received Outside the United States

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

## 7.18 Licensed Controlled Affiliate

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

## 7.19 BlueCard

Like all Blue Cross Blue Shield Licensees, BCBSHP participates in a program called "BlueCard". Whenever Members access health care services outside the geographic area BCBSHP serves, the claim for those services may be processed through BlueCard and presented to BCBSHP for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Members receive Covered Services within the geographic area served by an on-site Blue Cross or Blue Shield Licensee ("Host Blue"), BCBSHP will remain responsible to you for fulfilling BCBSHP's Contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for



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providing such services as contracting with its Participating Providers and handling all interaction with its Participating Providers. The financial terms of BlueCard are described generally below.

## 7.20 Liability Calculation Method Per Claim

The calculation of Member liability on claims for Covered Services incurred outside the geographic area BCBSHP serves and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price BCBSHP pays the Host Blue.

The methods employed by Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's provider contracts. The negotiated price paid to a Host Blue by BCBSHP on a claim for health care services processed through BlueCard may represent: (i) the actual price paid on the claim by the Host Blue to the health care provider ("Actual Price"), or (ii) an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care providers or one or more particular providers ("Estimated Price"), or (iii) an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claim transactions for all of its providers or for a specified group of providers ("Average Price"). An Average Price may result in greater variation to the Member from the Actual Price than would an Estimated Price.

Host Blue's using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statues mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate Member liability for any Covered Services in accordance with the applicable state statue in effect at the time the Member received those services.

## 7.21 Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from Participating Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, Utilization Review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.



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# 8. Payment of Benefits; General Information

## 8.1 Hospital Services

1. BCBSHP's payment to the Network or Participating Hospital where you receive care will be for the total amount of coverage you have under this Contract. All care must be consistent with the terms of this Contract. You may choose the Hospital at which care will be rendered; however, your out-of-pocket expenses are higher when you receive care from Non-Network Providers.
2. Payment of benefits for Eligible Charges will be made directly to you, the Subscriber, for treatment received in a Non-Network or Non-Participating Hospital if you do not assign benefits to such Hospital.
3. All determinations of payment are based on the applicable Reimbursement Rate or negotiated fees. Benefits are assignable.

## 8.2 Physician Services

1. We may pay either your Physician or you for any care which you have received. Payment will be for the amount due under this Contract. Benefits are assignable.
2. No salaried employee of a Hospital will receive direct payment for Physician services. This also includes resident Physicians and interns.
3. All determinations of payment are based on UCR Fees, Reimbursement Rate, negotiated fees, or a pre-determined fee schedule.

## 8.3 Network or Participating Provider Information

To find out if a Hospital or Physician is a Blue Cross Blue Shield Healthcare Plan of Georgia Network or Participating Provider, you may call them directly or call Customer Service. It is your responsibility to determine if the Provider you have chosen is a Network Provider for services to be rendered.

## 8.4 Other Services or Supplies

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

## 8.5 Contract Administration

1. For proper adjudication of claims under this Contract, it is agreed, and the Member consents, that all medical records involving any condition for which a claim is presented will be furnished at BCBSHP's request and all privileges with respect to such information, are waived. The Member agrees to participate and cooperate with BCBSHP in any pre-admission, concurrent or other medical review activity at any Hospital or Medical Facility as BCBSHP deems appropriate. This information will be kept confidential to the extent provided by law. Payment will not be provided where sufficient information cannot be obtained to properly adjudicate a claim.
2. Any person or entity having information about an illness or Injury for which benefits are claimed may give BCBSHP, at its request, any information (including copies or records) about the illness or Injury. In addition, BCBSHP may, with the Member's written consent, give any person or entity similar information at their request if they are providing similar benefits.
3. In making a decision on claims involving payment for services or supplies or days of care that are determined by BCBSHP to be Medically Necessary, BCBSHP reserves the right to obtain advisory opinions from Physician consultants in the appropriate specialty under consideration prior to reaching a decision. On reconsideration of denied Medical Necessity claims, BCBSHP further reserves the right to refer such cases to an appropriate peer review committee for an advisory opinion before BCBSHP renders its final determination on such claims.
4. BCBSHP will not cover the costs and/or copying of medical records.



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## 8.6 Unauthorized Use of Identification Card; Fraudulent Statements

1. If you permit a BCBSHP Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.
2. Fraudulent statements on Subscriber application forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Subscriber's coverage. This includes fraudulent acts to obtain medical services and/or prescription drugs.

## 8.7 Questions About Coverage or Claims

1. If you have questions about your coverage, contact the BCBSHP Customer Service Department. Be sure to always give your BCBSHP Member number.
2. If you wish to get a full copy of the Utilization Review program procedures, contact the Customer Service Department.

## 8.8 Explanation of Benefits

For all claims submitted by you or in your behalf, you will receive a notice (Explanation of Benefits) showing the amount of the charges, the amount paid by the program, and, if payment is partially or wholly denied, the reason. If your claim is denied, you can appeal as outlined below.

1. Write
   Customer Service Department
   Blue Cross Blue Shield Healthcare Plan of Georgia
   P.O. Box 7368
   Columbus, Georgia 31908
2. When asking about a claim, give the following information:
   - Your BCBSHP Member Number,
   - Patient name and address,
   - Date of service, type of service received, and
   - Provider name and address (Hospital or Physician).

## 8.9 We Want You To Be Satisfied

1. BCBSHP hopes that you will always be satisfied with the level of service provided to you and your family. BCBSHP realizes, however, that there may be times when problems arise or miscommunications occur which lead to feelings of dissatisfaction.
2. Complaints about BCBSHP Service

   As a BCBSHP Member, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process we have established to ensure that we give our fullest attention to your concerns. Please utilize it to BCBSHP when you are displeased with any aspect of services rendered.

   a. Call the Customer Service Department. The phone number is on your ID card. Tell us your problem and we will work to resolve it for you as quickly as possible.
   b. If you are not satisfied with our answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
   c. If, depending on the nature of your compliant, you remain dissatisfied after receiving our response, you will be offered the right to appeal our decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you; which will, hopefully, bring the matter to a satisfactory conclusion for you.
   d. If you remain dissatisfied upon conclusion of the first appeal level, you may again request an appeal of our decision. At the second appeal level, you have the opportunity to represent yourself



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in a formal Grievance Committee setting to present your own perspective in our concerted effort to bring this matter to a satisfactory resolution.

## 8.10 Summary of Grievances

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

## 8.11 Terms of Your Coverage

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

## 8.12 Acts Beyond Reasonable Control (Force Majeure)

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



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# 9. When Your Coverage Terminates

## 9.1 Termination of Coverage

BCBSHP may cancel this Contract in the event of any of the following:

1. You fail to pay Premiums in accordance with the terms of this Contract.
2. You perform an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for coverage.
3. We terminate, cancel or non-renew all coverage under a particular policy form, provided that:

   a. We provide at least 180 days notice of the discontinuance of the policy form to all insured and to the Commissioner.

   b. We offer you all other individual policies currently being offered or renewed by us for which you are otherwise eligible without regard to any health status related factor; and

   c. We act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

## 9.2 End of Coverage

1. Individual program membership for you and your enrolled family Members may be continued as long as you meet eligibility requirements. It ceases if you no longer meet eligibility requirements or if you fail to make any required contribution toward the cost of your coverage. In either instance, your coverage would end at the expiration of the grace period.
2. Coverage of an enrolled child ceases automatically when the child marries or attains age 19 except students covered up to and including age 25), whichever occurs first. Upon the date of the child/student reaches age 19 at which coverage would terminate under the provisions of the policy, the child/student shall be entitled to have issued to him or her, without evidence of insurability, upon application made to us within 45 days following the date the child/student reaches the age at which coverage would terminate and upon the payment of the appropriate premium. Coverage of an unmarried handicapped child over age 19 ceases if the child is found to be no longer totally or permanently disabled. Coverage of the spouse terminates automatically as of the date of divorce or death. Coverage will also cease when a covered person begins active duty with the Armed Services, the death of the Dependent or at the Member's request.
3. Coverage for a Domestic Partner ceases when the Domestic Partnership no longer exists.
4. NOTE: No termination shall prejudice an existing claim.

## 9.3 Conversion

1. Any divorced spouse or widow/widower may apply within 31 days to BCBSHP for a direct pay coverage contract most nearly similar to this Contract or any contract providing lesser coverage then being offered by BCBSHP. Such contract will be issued without evidence of insurability and will become effective upon payment of the charges for the new coverage. Such a contract is controlled by BCBSHP's regulations for Eligible Members.
2. Any time which you have earned toward any waiting periods under this Contract would be applied under a conversion contract. This rule also applies to time limits for legal defenses as explained in the "General Provisions" section.

## 9.4 Services After Cancellation of Coverage or Amendment of Policy

If you are an Inpatient in a facility on the day coverage under this Contract ends, we still provide the same benefits under this Contract for a limited time. This limited time will be the shortest of the following:

- through your date of discharge for that admission; or
- until your benefits for the covered Service are exhausted.



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IMPORTANT: No other benefits are available to you after your coverage ends. If you are an Inpatient on the day we change your Contract benefits (as opposed to a change in Premium), we will not change the Covered Services for that admission. The change will be effective immediately upon your date of discharge. However, any other changes, whether or not you are an Inpatient, will be effective on the date shown in the notice.



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# 10. Conditions of Benefits Provision

## 10.1 Hospital Inpatient Benefits

1. Hospital Inpatient benefits are available only if a Member is admitted as a bed patient to a Hospital on the order of a licensed Physician. The Member must be under the care of this Physician. The Physician must be on the staff of, or acceptable to, the Hospital at which the Member is a patient.
2. The service which the Member gets a Hospital is subject to all the rules and regulations of the Hospital selected. Such rules also control admission policies.
3. You can choose any legally constituted and approved Hospital you like for the care you receive; however, your Out-of-Pocket expenses are higher when you receive care from Non-Network Providers. BCBSHP does not guarantee your Admission to any Hospital. Also, BCBSHP does not guarantee that any particular service or type of room will be available even if requested by your Physician.

## 10.2 Right to Receive Necessary Information

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



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# 11. Notice

## 11.1 Change Notification - Members

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

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

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

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



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# 12. Definitions

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

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

**Allowable Charge**
The allowance for covered services, as determined by us in our sole discretion.

The amount on which applicable Deductible, Copayment and Coinsurance amounts for eligible Covered Services are calculated, as determined by us in our sole discretion.

**Applicant**
You. The person who applied for this Contract.

**Application for Coverage**
The original and any subsequent forms completed and signed by the Subscriber seeking coverage.

**Benefit Payment**
The amount we will pay for Covered Services.

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

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

**Brand Name Drug** – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

**Centers of Expertise Network**
A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein members access select types of benefits through a specific network of medical centers.

The network of health care professionals that entered into contracts with Blue Cross Blue Shield Healthcare Plan of Georgia, or one or more of its affiliates, to provide transplant or other designated specialty services.

**Chemical Dependency (Substance Abuse)**
The total psycho-physical state of mind that involves feelings of satisfaction and a drive to periodic or continuous administration of the chemical (drug) to produce pleasure or avoid discomfort.



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

**Coinsurance**
The percent that you must pay for a Covered Service per calendar year in addition to the Deductible and Copayment (if any).

**Combined Limit**
The maximum total of In-Network and Out-of-Network Benefits available for designated health service in the **Summary of Benefits**.

**Complications of Pregnancy**
Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy. Complications of Pregnancy shall not include false labor, cesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

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

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

**Copayment**
A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as $20 for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Typical Copayments are fixed or variable flat amounts for Physician office visits, Prescription Drugs or Hospital services. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered. Copayments may be collected by the provider of service or BCBSHP.

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

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



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

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

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

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

**Deductible**
The portion of the Eligible Charges you incur during a Benefit Period, unless otherwise specified, that you must pay each calendar year before we will begin to provide Benefit Payment. This amount is always your responsibility.

**Default Reimbursement Rate**
The rate paid to any provider that does not participate in any of BCBSHP's networks (or any of its affiliates). The default reimbursement rate will never be greater than the reimbursement rate for any contracted provider.

**Dependent**
The spouse, Domestic Partner and all unmarried children until attaining age 19. Children include natural children, legally adopted children and stepchildren. Also included are your children (or children of your spouse or Domestic Partner) for whom you have legal responsibility resulting from a valid court decree. Foster children whom you expect to raise to adulthood and who live with you in a regular parent-child relationship are considered children. However, for the purposes of this Contract, a parent-child relationship does not exist between you and a foster child if one or both of the child's natural parents also live with you. In addition, BCBSHP does not consider as a Dependent, welfare placement of a foster child under a welfare placement, as long as the welfare agency provides all or part of the child's support.

Children who are students (after high school) in an institution of higher learning at least five months each year (or were prevented from being enrolled due to illness or Injury) remain covered up to and including age 25.
Mentally retarded or physically handicapped children remain covered no matter what age. You must give us evidence of your child's incapacity within 31 days of attainment of age 19. This proof of incapacity may be required annually by us. Such children are not eligible under this Contract if they are already 19 or older at the time coverage is effective.

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



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**Domestic Partner**
Domestic Partner means he/or she has been your sole Domestic Partner for six months or more; he or she is mentally competent; he or she is at least 18 years old; is not related to you in any way (including by blood or adoption) that would prohibit you from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with you.

**Drug Formulary**
A document setting forth certain rules relating to the coverage of pharmaceutical by BCBSHP, that may include but not be limited to (1) a listing of preferred and non-preferred prescription medications that are covered and/or prioritized in order of preference by BCBSHP, and are dispensed to Members through pharmacies that are Network Providers and (2) Pre-certification rules. This list is subject to periodic review and modification by BCBSHP, at its sole discretion. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Drug Formulary.

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

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

**Eligible Charges**
Those charges for services and supplies (a) defined as Covered Services and not excluded under the Member's Contract; (b) that are Medically Necessary; and (c) that are provided in accordance with the Member's Contract. Eligible Charges are determined by: (a) BCBSHP's Usual, Customary and Reasonable (UCR) Fees; (b) a provider's contracted fee schedule; (c) the applicable Reimbursement Rate; or (d) negotiated fees. All payment determinations for Hospital services are based on the applicable Reimbursement Rate. Reimbursement for Network, Participating and Out-of-Network, and Non-Participating Providers is based on Eligible Charges for the type of service a Member receives, (for example, Hospital or Physician services).

Reimbursement for Non-Contracted Providers is determined by our Default Reimbursement Rate.

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

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta 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



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

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

**Family Coverage**
Coverage for you, your spouse, and any eligible children.

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

**Full Time Student**
Children who were Full-Time Students (after high school) in an institution of higher learning at least five months each year (or were prevented from being so enrolled due to illness or Injury).

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

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

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

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

**Hospice Care Program**
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family Members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

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

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

**Identification Card**
The latest card given to you showing your Member numbers, the type coverage you have and the date coverage becomes effective.



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**Individual Coverage**
Coverage for you only.

**Ineligible Charges**
Charges for health care services that are not Eligible Charges because the services are not Medically Necessary. Such charges are not eligible for payment.

**Ineligible Hospital**
A facility which does not meet the minimum requirements to become a Network or Participating Hospital. Services rendered to a Member by such a Hospital are not eligible for payment.

**Ineligible Provider**
A provider which does not meet the minimum requirements to become a Participating Provider or with which BCBSHP does not directly contract. Services rendered to a Member by such a provider are not eligible for payment.

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

**Injury**
Bodily harm from a non-occupational accident.

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

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

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

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

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient’s condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the Physician, health care provider or Hospital;
- not primarily Custodial Care; and
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.



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

**Mental Health Disorders**
Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or chemical dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, chemical dependency disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

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

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

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

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

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

**Non-Network Provider**
A Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have a Network Provider Contract with BCBSHP at the time you receive the services for which you are seeking. Benefit payments and other provisions of this Contract are limited when a Member uses the services of Non-Network Providers.

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

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



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

**Out-of-Pocket Limit**
The maximum dollar amount that you pay towards certain Coinsurance before your policy covers 100% of the Eligible Charge for certain services for the rest of the Benefit Period or until you reach your Lifetime Maximum. Not all monies that you pay toward your healthcare costs are counted toward your Out-of-pocket limit. This phrase is explained in detail in the **How Your Benefits Work For You** article.

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

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

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

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

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

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

**Prescription Drug**
A drug which cannot be purchased except with a prescription from a Physician and which must be dispensed by a Pharmacist.

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



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**Provider**
Any physician, health care practitioner, pharmacy, supplier or facility, including, but not limited to, a hospital, clinical laboratory, freestanding ambulatory surgery facility, skilled nursing facility, long term acute care facility, or home health care agency holding all licenses required by law in the State of Georgia to provide health care services.

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

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

**Semiprivate Room**
A Hospital room which contains two or more beds.

**Similar Drugs**
Similar Drugs are those within a certain therapeutic class such as insomnia drugs, oral contraceptives, seizure drugs, etc.

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

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

**Specialty Drugs**
High cost injectable, infused, oral or inhaled medications that typically require close supervision and monitoring of their effect on the patient by a medical professional. Specialty Drugs often require special handling such as temperature-controlled packaging and overnight delivery and are often unavailable at retail pharmacies. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

**Specialty Pharmacy**
A pharmacy which dispenses biotech drugs for rare and chronic diseases via scheduled drug delivery either to the Member's home or to a Physician's office. These pharmacies also provide telephonic therapy management to ensure safety and compliance.

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

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

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



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**Technology Assessment Criteria**
Five criteria all investigative procedures must meet in order to be covered procedures under this Contract:
1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology of health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternative.
5. The technology must be beneficial in practice.

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

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

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

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

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

**Therapeutic/Clinically Equivalent**
Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. "Therapeutic/Clinically Equivalent" means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. Therapeutic/Clinically Equivalent determinations are based on industry standards and reviewed by such organizations as The Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services.

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

**Urgent Care**
The services you get for a sudden, serious, or unexpected illness, injury or condition to keep your health from getting worse. It is not an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat the health problem.

**Usual-Customary-Reasonable (UCR) Fee (as determined by BCBSHP)**
Usual Fee: The fee a Physician most frequently receives as reimbursement for the procedure performed.

Customary Fee: Based on a competitive profile of the usual fees received as reimbursement by similar Physicians in a given geographic area for the procedure performed, according to our records.



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Reasonable Fee: The fee different from usual or customary fees because of unusual circumstances involving complications requiring additional time, skill and experience.

If it does not pay at contracted rates, BCBSHP may pay up to the usual fee not to exceed the customary fee, unless special circumstances or complications occur, in which case we may consider the reasonable fee.

All payments are based on the UCR applicable to the Member's actual residence (i.e., local UCR).

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

**Waiting Period**
The specific amount of time that must pass before you are eligible to receive benefits from this Contract for pre-existing conditions. These conditions are explained in the "Limitations and Exclusions" article.



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an Independent Licensee of the Blue Cross Blue Shield Association



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