Health Reimbursement Arrangement (HRA)

Summary Plan Description (SPD)

FOR

HRA OPTIONS: GOLD, SILVER and BRONZE

Administered By

Effective Date: January 1, 2014

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

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

Introduction

This Summary Plan Description ("SPD") gives you a description of your Benefits while you are enrolled under the State Health Benefit Plan (the "Plan"). You should read this SPD carefully and keep it handy for reference. A thorough understanding of your coverage will allow you to use your Benefits wisely. If you have any questions about the Benefits shown in this SPD, please call the appropriate vendor's Customer Service number on the back of your Identification Card.

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

The Plan Benefits described in this SPD are for eligible Health Plan Members only. The health care services are subject to the limitations and Exclusions, Deductible and Coinsurance rules given in this SPD. Any group plan or certificate which you may have received before will be replaced by this SPD.

Note: Please refer to the 2014 Eligibility & Enrollment Provisions document that contains the Plan's eligibility requirements and Benefits payable under the HRA options for services provided on or after January 1, 2014 posted separately as part of the SPD.

Many words used in this SPD have special meanings (e.g., Employer, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" Section. See these definitions for the best understanding of what is being stated. Throughout this SPD, you will also see references to "we", "us", "our", "you" and "your". The words "we", "us" and "our" mean the Department of Community Health, Division of SHBP. The words "you" and "your" mean the Covered Person and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also, be sure to check the Medical Claims Administrator's website, www.bcbsga/shbp.com for details on how to find a Provider, get answers to questions, and access valuable health and Well-Being tips. For more information about your Pharmacy Benefits see the Pharmacy Section of this SPD or go to your Pharmacy Claims Administrator's website, www.express-scripts.com/GeorgiaSHBP. For more information about your Wellness Benefits, see the Wellness Section of this SPD or go to your Wellness Administrator's website, www.BeWellSHBP.com. If you have any enrollment or eligibility questions, call the SHBP Call Center at: 1-800-610-1863 or visit: www.myshbpga.adp.com.

Important: This is not an insured benefit Plan. The Benefits described in this SPD or any rider or amendments attached hereto are funded by the Plan Sponsor who is responsible for a portion of their payment. BCBSGa provides administrative medical claims payment services only, and ESI only provides administrative pharmacy claims payment services. Healthways, Inc., is the Well-Being program administrator.

How to Get Language Assistance

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

Resources/Contact Information State Health Benefit Plan (SHBP)

	Member	Website
Medical - Blue Cross Blue Shield of Georgia Customer Service Hours: 8:00 a.m. – 8:00 p.m. ET; Monday – Friday	1-855-641-4862 (TTY 711)	www.bcbsga.com/shbp
Wellness - Healthways Customer Service* Hours: 8:00 a.m. – 8:00 p.m. ET; Monday – Friday	1-888-616-6411	www.BeWellSHBP.com
Pharmacy - Express Scripts Customer Service Hours: 24 hours a day / 7 days a week	1-877-841-5227	www.express-scripts.com/GeorgiaSHBP
SHBP Call Center Hours: 8:30 a.m. – 5:00 p.m. ET; Monday – Friday	1-800-610-1863	www.mySHBPga.adp.com

Additional Information	Member Services	Website
Centers for Medicare & Medicaid (CMS) 24 hours a day / 7 days a week	1-800-633-4227 TTY 877-486-2048	www.medicare.gov

Table of Contents

Introduction 2
How to Get Language Assistance 2
Resources/Contact Information State Health Benefit Plan (SHBP) 3
Table of Contents 4
Schedule of Benefits 8
Emergency Services 15
Home Care 15
Transportation and Lodging Limit 16
Infertility Services 17
Inpatient Facility Services 17
Maternity and Reproductive Health Services 18
Chiropractic Care / Manipulation Therapy 22
Physical & Occupational Therapy 22
Speech Therapy 22
Respiratory and Pulmonary 22
Cardiac Rehabilitation 22
Dialysis / Hemodialysis 22
Radiation / Chemotherapy / Non-Preventive Infusion & Injection 22
Physical & Occupational Therapy 24
Speech Therapy 24
Respiratory and Pulmonary 24
Cardiac Rehabilitation 24
How Your Plan Works 28
In-Network Services 28
After Hours Care 29
Out-of-Network Services 29
How to Find a Provider in the Network 29
Your Cost-Shares 30
The BlueCard Program 30
Identification Card 31
Getting Approval for Benefits 31
Types of Requests 31
Request Categories 33
Decision and Notice Requirements 33
Voluntary Incentive Program 38
AIM Imaging Cost & Quality Program 38
Individual Case Management 38
What's Covered 42
Allergy Services 43
Ambulance Services 43
Important Notes on Air Ambulance Benefits 43
Hospital to Hospital Transport 44
Autism Services 44
Behavioral Health Services 44
Cardiac Rehabilitation 44
Chemotherapy 44
Chiropractic Services 44

Clinical Trials 45
Cancer Clinical Trial Programs for Children 46
Dental Services (All Members / All Ages) 46
Preparing the Mouth for Medical Treatments 46
Oral Care 46
Treatment of Accidental Injury 46
Other Dental Services 46
Diabetes Equipment, Education, and Supplies 47
Diagnostic Services 47
Diagnostic Laboratory and Pathology Services 47
Diagnostic Imaging Services and Electronic Diagnostic Tests 47
Advanced Imaging Services 48
Dialysis 48
Durable Medical Equipment and Medical Devices 48
Orthotics 49
Prosthetics 49
Medical and Surgical Supplies 49
Blood and Blood Products 49
Emergency Care Services 50
Emergency Services 50
Home Care Services 51
Home Infusion Therapy 51
Hospice Care 51
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services 52
Prior Approval and Precertification 52
Infertility Services 54
Inpatient Services 54
Inpatient Hospital Care 54
Inpatient Professional Services 55
Maternity and Reproductive Health Services 55
Maternity 55
Contraceptive Benefits 56
Sterilization Services 56
Abortion Services 56
Infertility Services 56
Mental Health and Substance Abuse Services 56
Nutritional Counseling 57
Occupational Therapy 57
Office Visits and Doctor Services 57
Orthotics 57
Outpatient Facility Services 57
Physical Therapy 58
Preventive Care 58
Prosthetics 60
Pulmonary Therapy 60
Radiation Therapy 60
Rehabilitation Services 60
Habilitative Services 60
Respiratory Therapy 60

Skilled Nursing Facility....60
Speech Therapy....61
Surgery....61
Oral Surgery....61
Reconstructive Surgery....61
Mastectomy Notice....62
Temporomandibular Joint (TMJ) and Craniomandibular Joint Services....62
Therapy Services....62
Physical Medicine Therapy Services....62
Early Intervention Services....63
Other Therapy Services....63
Transplant Services....64
Urgent Care Services....64
Vision Services (All Members / All Ages)....64
Drugs Administered by a Medical Provider....64
Important Details About Prescription Drug Coverage....65
Prior Authorization....65
Step Therapy....65
Therapeutic Substitution....65
Disease Management (DM) Coinsurance Waiver Program....65
What's Not Covered....66
Claims Payment....71
Maximum Allowed Amount....71
General....71
Provider Network Status....72
Member Cost Share....74
Authorized Services....74
Notice of Claim & Proof of Loss....75
Medical Claim Forms....75
Payment of Benefits....75
Out-of-Area Services....76
BlueCard® Program....76
Member Liability Calculation....77
Exceptions....77
Insured Under More Than One Plan....78
Order of Benefit Determination Rules....79
Effect on the Benefits of This Plan....80
Right to Receive and Release Needed Information....81
Facility of Payment....81
Right of Reimbursement....81
Subrogation and Reimbursement....82
Member Rights and Responsibilities....83
Your Right To Appeal....85
Termination and Continuation of Coverage....90
General Provisions....90
Form or Content of SPD....90
Government Programs....90
Medical Policy and Technology Assessment....90
Medicare....90

Governmental Health Care Programs....91
Modifications....91
Not Liable for Provider Acts or Omissions....91
Policies and Procedures....91
Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc.....91
Plan Administrator's Sole Discretion....92
Reservation of Discretionary Authority....92
Right of Recovery....92
Unauthorized Use of Identification Card....92
Fraud....93
Value of Covered Services....93
Waiver....93
Workers' Compensation....93
Medical Definitions....94
Choice of Primary Care Physician....124
Access to Obstetrical and Gynecological (ObGyn) Care....124
Special Enrollment Notice....124
Identification Card, or contact your Benefit Coordinator/Payroll Location.....125
Statement of Rights under the Newborns' and Mothers' Health Protection Act....125
Patient Protection and Affordable Care Act ("PPACA")....125
Patient Protection Notices....125
Health Insurance Portability and Accountability Act Notice of Information Privacy Practices....127
Mental Health Parity and Addiction Equity Act Opt-Out Notice....131
Centers for Medicare & Medicaid Services Medicare Part D Creditable Coverage Notice....132

Schedule of Benefits

In this Section, you will find an outline of the Benefits included in your Plan and a summary of any Deductibles and Coinsurance that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs Section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" Section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, terms and conditions of this SPD including but not limited to any endorsements, amendments, or riders.

All Options within this SPD are consumer-driven Health Reimbursement Arrangement Plan options that offer medical, pharmacy and Well-Being Benefits. The Covered Services and the Provider Networks are the same in each medical Plan option.

To receive the highest level of Benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Medical Claims Administrator will allow for a Covered Service. When you use an Out-of-Network Provider, you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount, as well as any Coinsurance, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" Section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges. The In-Network and Out-of-Network Deductibles are separate and cannot be combined. The In-Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined. P**rescription costs do not apply to the Deductible or Out-of-Pocket Maximum.**

Benefit Period	Calendar Year
Dependent Age Limit	**To the end of the month in which the child reaches age 26** **Please see the separate —2014 Eligibility &Enrollment Provisions document posted at www.dch.georgia.gov/shbp-summary-plan-descriptions for further details.**

Important: *For Out-of-Network Providers, the plan does not accept assignment of Benefits. You will receive a payment of Benefits and it will be your responsibility to pay that to the Out-of-Network Provider directly.*

Deductible*	Gold Plan		Silver Plan		Bronze Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	Out-of-Network
You	**$1,500**	**$3,000**	**$2,000**	**$4,000**	**$2,500**	**$5,000**
You + Spouse	**$2,250**	**$4,500**	**$3,000**	**$6,000**	**$3,750**	**$7,500**
You + Children	**$2,250**	**$4,500**	**$3,000**	**$6,000**	**$3,750**	**$7,500**
You + Family	**$3,000**	**$6,000**	**$4,000**	**$8,000**	**$5,000**	**$10,000**
*** See the box below**						

The Deductible applies to all Covered Services unless otherwise indicated.

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

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

The In-Network and Out-of-Network Deductibles are separate and cannot be combined. **Prescription costs do not apply to the deductible or out-of—pocket maximum.**

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

SHBP CONTRIBUTIONS TO YOUR HRA ACCOUNT	Gold Plan	Silver Plan	Bronze Plan
You	$400	$200	$100
You + Spouse	$600	$300	$150
You + Children	$600	$300	$150
You + Family	$800	$400	$200

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

Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network billed charge and the Maximum Allowed Amount.

Note: The Coinsurance listed above may not apply to all Covered Services. Some Covered Services may have a different Coinsurance. Please see the rest of this Schedule for details.

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

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

The Out-of-Pocket Maximum an individual can meet cannot be more than the You Out-of-Pocket Maximum.

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

- **Charges over the Maximum Allowed Amount,**
- **Penalties for not getting required pre-authorization / Pre-certification of services,**
- **Coinsurance paid toward Prescription Drugs,**
- **Amounts you pay for non-Covered Services.**
- **HRA dollars will reduce the Out-of-Pocket Maximum.**

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

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

Once the Out-of- Pocket Limit is satisfied, you will not have to pay any additional Deductibles or Coinsurance for the rest of the Benefit Period, except for the services listed above.

Important Notice about Your Cost Shares

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

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many areas of the tables you will see the statement, "Benefits are based on the setting in which Covered Services are received". In these cases, you should determine where you will receive the service (i.e., in a Doctor's office, at an outpatient Hospital facility, etc.). Look up the location of where you will receive the medical service to find out which Cost Share will apply.

For example: you may get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the Doctor's office, look under "Office Visits". For services in the outpatient Hospital facility, look under "Outpatient Facility Services". For services during an Inpatient stay, look under "Inpatient Services".

Covered Services	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Allergy Services	**Benefits are based on the setting in which Covered Services are received.**			
Ambulance Services (Air and Water)	15% Coinsurance per trip after Deductible	20% Coinsurance per trip after Deductible	25% Coinsurance per trip after Deductible	**Same as In-Network**
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. **Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see —Getting Approval for Benefits for details.**				
Ambulance Services (Ground)	15% Coinsurance per trip after Deductible	20% Coinsurance per trip after Deductible	25% Coinsurance per trip after Deductible	**Same as In-Network**
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. **Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see—Getting Approval for Benefits for details.**				
Behavioral Health Services	**See —Mental Health and Substance Abuse Services.**			
Cardiac Rehabilitation	**Benefits are based on the setting in which Covered Services are received. See —Therapy Services for details on Benefit Maximums.**			
Chemotherapy	**Benefits are based on the setting in which Covered Services are received.**			
Clinical Trials / Cancer Clinical Trial Programs for Children	**Benefits are based on the setting in which Covered Services are received. See —What's Covered Section for Clinical Trials.**			

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Dental Services All Members / All Ages	**Benefits are based on the setting in which Covered Services are received. See—What's Covered Section for Dental Services.**			
Diabetes Equipment, Education, and Supplies	**Benefits are based on the setting in which Covered Services are received.**			
Diagnostic Services	**Benefits are based on the setting in which Covered Services are received.**			
Diagnostic Services Outpatient Facility	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Dialysis / Hemodialysis	**Benefits are based on the setting in which Covered Services are received**			
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier) **Foot Orthotics covered for diabetes diagnosis**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Foot Orthotics Benefit Maximum	**1 pair every 3 years**			
Hearing Exams, tests & fittings	15% Coinsurance after Deductible	20% Coinsurance after Deductible	15% Coinsurance after Deductible	**Same as In-Network**
Hearing Aids	0% Coinsurance No Deductible	0% Coinsurance No Deductible	0% Coinsurance No Deductible	**Same as In-Network**

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Hearing Aids Benefit Maximum	**Limited to $1,500 every 5 years.**			
Note: Coverage is excluded for hearing aids to correct degenerative hearing loss.				
Wigs	0% Coinsurance after Deductible	0% Coinsurance after Deductible	0% Coinsurance after Deductible	**Same as In-Network**
o Wigs Benefit Maximum	**$750 per Lifetime, Wigs are excluded regardless of the reason for the hair loss, with the exception of hair loss relating to cancer/chemotherapy treatment.**			
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.				

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Emergency Services				
Emergency Room				
• **Emergency Room Facility Charge**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**Same as In-Network**
• **Emergency Room Doctor Charge**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**Same as In-Network**
• **Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**Same as In-Network**
• **Advanced Diagnostic Imaging (including MRIs, CAT scans)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**Same as In-Network**
Note: Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.				
Home Care				
• **Home Care Visits**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Home Dialysis**	**15% Coinsurance after Deductible**	**20% Coinsurance after Deductible**	**25% Coinsurance after Deductible**	**40% Coinsurance after Deductible**

• Home Infusion Therapy	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	40% Coinsurance after Deductible
• **Other Home Care Services / Supplies**	**15% Coinsurance after Deductible**	**20% Coinsurance after Deductible**	**25% Coinsurance after Deductible**	**40% Coinsurance after Deductible**

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Home Infusion Therapy	**See —Home Care.**			
Hospice Care				
• **Home Care** • **Respite Hospital Stays**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.				
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	**Benefits are based on the setting in which Covered Services are received.**			
• **Precertification required**				
• **Transportation and Lodging**	15% Coinsurance No Deductible	20% Coinsurance No Deductible	25% Coinsurance No Deductible	**Not Covered unless BDCT[1] Facility used.**
• **Transportation and Lodging**	**Covered, as approved by BCBSGa, up to $10,000 per transplant Limit Out-of-Network not covered Lodging $50 per day for double occupancy**			
• **Donor Search**	15% Coinsurance No Deductible	20% Coinsurance No Deductible	25% Coinsurance No Deductible	**Not Covered unless BDCT Facility used.**
• **Donor Search Limit**	**Covered, as approved by us, up to $30,000 Lifetime Maximum**			

BDCT – Blue Distinction Center for Transplants

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
(Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure)	**Out-of-Network not covered.**			
Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	**Out-of-Network (All Plans)**
Infertility Services	**See—Maternity and Reproductive Health Services.**			
Inpatient Facility Services				
Facility Room & Board Charge:				
• **Hospital / Acute Care Facility**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Skilled Nursing Facility**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**Not Covered**
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	**120 days per Benefit Period**			
• **Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Doctor Services for:				
• **General Medical Care / Evaluation and Management (E&M)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Surgery**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Maternity and Reproductive Health Services				
• **Maternity Services** **If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.** **Note: Deductible applies to mother and well-newborn charges.**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Prenatal Office Visit Services	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Primary Care Physician / Provider (PCP)	**15% Coinsurance after Deductible**	**20% Coinsurance after Deductible**	**25% Coinsurance after Deductible**	**40% Coinsurance after Deductible**

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Specialty Care Physician / Provider (SCP)	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Inpatient Services (Delivery)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Inpatient Facility Services** **Note: Deductible applies to mother and baby charges.**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Inpatient Doctor Services**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Newborn / Maternity Stays: For well newborn, a separate deductible is applied to mother and baby claims.				
• Infertility Limited to diagnostic services. Treatment of infertility or for the purpose to achieve pregnancy, is not covered.	**Benefits are based on the setting in which Covered Services are received.**			
Mental Health and Substance Abuse Services				
• **Inpatient Facility Services**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Inpatient Doctor Services**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Outpatient Facility Services**	**15% Coinsurance after Deductible**	**20% Coinsurance after Deductible**	**25% Coinsurance after Deductible**	**40% Coinsurance after Deductible**

• Outpatient Doctor Services	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	40% Coinsurance after Deductible
• Partial Hospitalization Program / Intensive Outpatient Program Services	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
• Office Visits	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	40% Coinsurance after Deductible
Occupational Therapy	Benefits are based on the setting in which Covered Services are received. See —Therapy Services for details on Benefit Maximums.			
Office Visits and Physician Services				
• Primary Care Physician / Provider (PCP)	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	40% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP)	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	40% Coinsurance after Deductible
• Retail Health Clinic Visit	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	40% Coinsurance after Deductible
• Nutritional Counseling – Children	0% Coinsurance No Deductible	0% Coinsurance No Deductible	0% Coinsurance No Deductible	Same as In-Network
•				
o Nutritional Counseling – Benefit Maximum	Nutritional Counseling Children (Childhood Obesity) Benefit Maximum: For ages 3-18 with a 4 visit limitation per calendar year for physicians and 4 visit limitation per plan year for Registered Dietitians who qualify as determined by their physician.			
• Nutritional Counseling – Adults	0% Coinsurance No Deductible	0% Coinsurance No Deductible	0% Coinsurance No Deductible	Same as In-Network
o Nutritional Counseling – Benefit Maximum	Nutritional Counseling Adults Benefit Maximum: 3 visits per medical condition per lifetime.			

2014 SHBP Summary Plan Description

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
• **Allergy Testing & Treatment**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Diagnostic Labs (non-preventive) (i.e., reference labs)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Injections (Includes administration charge)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Diagnostic X-ray (non-preventive)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Diagnostic Tests (non-preventive; including EKG)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Diagnostic Hearing Tests**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Advanced Diagnostic Imaging (including MRIs, CAT scans)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Office Surgery**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Therapies: See —Therapy Services for details on Benefit Maximums.				

• Chiropractic Care / Manipulation Therapy	**15% Coinsurance after Deductible**	**20% Coinsurance after Deductible**	**25% Coinsurance after Deductible**	**40% Coinsurance after Deductible**
• **Physical & Occupational Therapy**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Speech Therapy**	**15% Coinsurance after Deductible**	**20% Coinsurance after Deductible**	**25% Coinsurance after Deductible**	**40% Coinsurance after Deductible**

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
• **Respiratory and Pulmonary**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Cardiac Rehabilitation**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Dialysis / Hemodialysis**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Radiation / Chemotherapy / Non-Preventive Infusion & Injection**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
See —Therapy Services for details on Benefit Maximums.				
• **Prescription Drugs Administered in the Provider's Office**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Orthotics **Summary Plan Description**	**See —Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical**			

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
		Supplies		
Outpatient Facility Services				
Facility Surgery Charge	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Doctor Surgery Charges**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist.**	**15% Coinsurance after Deductible**	**20% Coinsurance after Deductible**	**25% Coinsurance after Deductible**	**40% Coinsurance after Deductible**

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
• **Other Facility Charges (for procedure rooms or other ancillary services)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Diagnostic Lab**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Diagnostic X-ray**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Diagnostic Hearing Tests**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Advanced Diagnostic Imaging (including MRIs, CAT scans)**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Therapies: See —Therapy Services for details on Benefit Maximums.				
• **Chiropractic Care / Manipulation Therapy**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Physical & Occupational Therapy**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Speech Therapy**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Respiratory and Pulmonary**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Cardiac Rehabilitation**	**15% Coinsurance after Deductible**	**20% Coinsurance after Deductible**	**25% Coinsurance after Deductible**	**40% Coinsurance after Deductible**

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
• **Dialysis / Hemodialysis**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
• **Radiation / Chemotherapy / Non-Preventive Infusion & Injection**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
See —Therapy Services for details on Benefit Maximums.				
• **Prescription Drugs Administered in an Outpatient Facility**	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Physical Therapy	**Benefits are based on the setting in which Covered Services are received. See —Therapy Services for details on Benefit Maximums.**			
Preventive Care **Note: Certain preventive care services are only covered when provided by an in-network provider and properly coded as preventive care.**	0% No Copayment, Deductible or Coinsurance	0% No Copayment, Deductible or Coinsurance	0% No Copayment, Deductible or Coinsurance	**Not Covered**
Prosthetics	**See —Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical**			
Pulmonary Therapy	**Benefits are based on the setting in which Covered Services are received. See —Therapy Services for details on Benefit Maximums.**			
Radiation Therapy	**Benefits are based on the setting in which Covered Services are received.**			
Rehabilitation Services	**Benefits are based on the setting in which Covered Services are received. See —Therapy Services for details on Benefit Maximums.**			
Respiratory Therapy	**Benefits are based on the setting in which Covered Services are received.**			
	See —Inpatient Services.			

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Speech Therapy	**Benefits are based on the setting in which Covered Services are received. See —Therapy Services for**			
Surgery	**Benefits are based on the setting in which Covered Services are received.**			
Temporomandibular and Craniomandibular Joint Treatment	**Benefits are based on the setting in which Covered Services are received.**			
o Occlusal Guard Benefit Maximum	**$500 per Lifetime**			
o Non-surgical Treatment Benefit Maximum	**$1,000 per Lifetime (x-rays not included)**			
Therapy Services	**Benefits are based on the setting in which Covered Services are received.**			
Benefit Maximum(s):	**Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.**			
• **Cardiac Rehabilitation**	**40 visits per Benefit Period**			
• **Chiropractic Care / Manipulation Therapy**	**20 visits per Benefit Period**			
• **Occupational Therapy**	**40 visits per Benefit Period**			
• **Physical Therapy**	**40 visits per Benefit Period**			
• **Respiratory Therapy**	**40 visits per Benefit Period**			
• **Speech Therapy**	**40 visits per Benefit Period**			
Note: The limits for physical, occupational, speech therapy, respiratory and cardiac will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit. **When physical, occupational, speech therapy, or cardiac rehabilitation is rendered in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.**				
Transplant Services	**See —Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services.**			

Benefits	Gold Plan In-Network	Silver Plan In-Network	Bronze Plan In-Network	Out-of-Network (All Plans)
Urgent Care Services	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
If you get urgent care at a hospital or other outpatient facility, please refer to —Outpatient Facility Services for details on what you will pay.				
Vision Services (All Members / All Ages) (Non-routine) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit when provided by an in-network provider and properly coded as preventive care. **Note**: Vision hardware, glasses or contact lenses are only covered following cataract surgery.	15% Coinsurance after Deductible	20% Coinsurance after Deductible	25% Coinsurance after Deductible	**40% Coinsurance after Deductible**
Vision Exam (Routine) Limited to one (1) every 24 months	**100% Coverage**	**100% Coverage**	**100% Coverage**	**Not Covered**

How Your Plan Works

Introduction

If you have any questions about this SPD, please call the Member Service number located on the back of your Identification (ID) Card.

Your Plan is a Point of Service ("POS") plan which the same services provided Out-of-Network not covered. Assignment of Benefits will not be honored. The Plan has two sets of Benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more in out-of-pocket costs.

In-Network Services

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

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

In-Network Providers include Primary Care Physicians / Providers ("PCP"), Specialists (Specialty Care Physicians / Providers - SCPs, other professional Providers, Hospitals, and other Medical Facilities who contract with the Medical Claims Administrator to care for you.

To see a Doctor – when you call the Doctor's Office:

- Tell them you are a BCBSGa State Health Benefit Plan Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not be required to file any claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this SPD.

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

Please refer to the "Claims Payment" Section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. Call your Doctor's office for after hours instructions if you need care in the evenings, weekends, or during a holiday, and cannot wait until the office reopens. If you're not sure where to go for care and your Doctor is not available, you can also call the 24/7 Nurse line at 1-866-787-6361. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

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

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount, plus any Deductible and/or Coinsurance;

2. You may have higher cost sharing amounts (i.e., Deductibles, and/or Coinsurance);

3. You will have to pay for services that are not Medically Necessary;

4. You will have to pay for non-covered services;

5. You may have to file claims; and

6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

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

How to Find a Provider in the Network

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

- See your Plan's directory of In-Network Providers at: www.bcbsga.com/shbp, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.

- Check with your Doctor or Provider.

Note: Not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases, you will have to go to a lab in the Reference Lab Network to get In-Network Benefits. Reference Lab is a freestanding lab outside of the Physician's office, for example LabCorp or Quest. Please call Customer Service before you get services for more information.

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

Note: BCBSGa has several networks. A Provider that is In-Network for one plan may not be In-Network for another. Be sure to check the BCBSGa website at www.bcbsga.com/shbp or call Customer Service to confirm your Provider is in the Georgia State Health Benefit Plan POS network.

Your Cost-Shares

Your Plan may involve Deductibles and/or Coinsurance that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Maximum, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also, read the "**Definitions**" Section for a better understanding of each type of cost share.

The BlueCard Program

BCBSHP is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting BCBSHP to use the Blue Cross and Blue Shield Service Marks in the State of Georgia. Although BCBSHP is the Medical Claims Administrator and is licensed in Georgia, you will have access to Providers participating in the Blue Cross and Blue Shield Association BlueCard network across the country.

"BlueCard." The BlueCard network lets you get Covered Services at the In-Network cost-share when you are traveling outside of the State of Georgia and need health care, as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider. The Provider will send your claims to BCBSGa.

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

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

In a non-Emergency situation, you can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or by calling the number on the back of your Identification Card.

Identification Card

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

Getting Approval for Benefits

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

If you have any questions about the information in this Section, you may call the Customer Service phone number on the back of your Identification Card

Types of Requests

- **Prior Authorization –** Network Providers must obtain Prior Authorization in order for you to get Benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, pharmacy and therapeutics guidelines. The Medical Claims Administrator may decide that a service that was first prescribed or requested is not Medically Necessary if you have not tried other treatments which are more cost effective.

- **Precertification –** A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell the Medical Claims Administrator within 48 hours of the admission. For labor/childbirth admissions, Precertification is not needed unless there is a problem regarding the mother and/or the baby which causes either not to be sent home at the same time.

- **Predetermination –** An optional, voluntary Prospective or Continued Stay Review can be requested for a benefit coverage determination regarding a service or treatment. The Medical Claims Administrator will check your Plan to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Plan, or is it Experimental / Investigational as that term is defined in this Plan.)

- **Post Service Clinical Claims Review –** A Retrospective review for a benefit coverage determination: (1) to decide the Medical Necessity; (2) to determine if services rendered is a Covered Benefit; (3) to determine if it is of an Experimental / Investigational nature of a service, treatment or admission that did not need Precertification, and (4) if it did not have a Predetermination review performed. The reviews are done for a service, treatment or admission in which the Medical Claims Administrator has a related clinical coverage guideline policy, and are typically initiated by the Medical Claims Administrator.

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

Who is responsible for Precertification	
Services provided by an In-Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield Healthcare Plan, Inc.; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Medical Claims Administrator's parent company.	Provider
Services provided by BlueCard Providers outside the service areas of the states listed in the column to the left, BlueCard Providers in other states not listed, and any Out-of-Network/Non-Participating Provider.	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For an Emergency admission -- you, your authorized representative or Doctor must contact the Medical Claims Administrator within 48 hours.

The Medical Claims Administrator will use clinical coverage guidelines, such as medical policy, preventative care clinical coverage guidelines, and other applicable policies to help make Medical Necessity decisions, including decision about Prescription and Specialty Drug services. Medical polices and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Medical Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

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

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

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

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

You may find out whether a Provider is taking part in certain programs by checking your online Provider directory or by contacting Customer Service telephone number on the back of your ID card.

Request Categories

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

- **Prospective –** A request for Precertification or Predetermination that is conducted before the service, treatment or admission into a health care Facility.

- **Continued Stay Review -** A request for Precertification or Predetermination that is conducted during the course of treatment or admission into a health care Facility.

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

Decision and Notice Requirements

The Medical Claims Administrator will review requests for Benefits according to the timeframes listed below. Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on the back of your Identification Card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Emergent.	**72 hours from the receipt of request**
Prospective Non-Emergent.	**15 calendar days from the receipt of the request**
Continued Stay Review when Hospitalized at the time of the request.	**72 hours from the receipt of the request and prior to expiration of current certification.**
Continued Stay Review Emergent when request is received more than 24	**24 hours from the receipt of the request**

Request Category	Timeframe Requirement for Decision and Notification
hours before the expiration of the previous authorization.	
Continued Stay Review Emergent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists.	**72 hours from the receipt of the request**
Continued Stay Review Non-Emergent	**15 calendar days from the receipt of the request**
Retrospective	**30 calendar days from the receipt of the request**

If more information is needed to make a decision, the Medical Claims Administrator will tell the requesting Provider (and send written notice to you or your authorized representative) of the specific information needed to finish the review. If the Medical Claims Administrator does not get the specific information needed or if the information is not complete by the timeframe identified in the written notice, a decision will be made based upon the information received. The Medical Claims Administrator will give notice of its decision as required by state and federal law. Notice may be given by the following methods:

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

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

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

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

Members Must Call the BCBSGa Personal Health Coach Team at 1-855-668-6442 for Pre-Certification (also known as Prior Authorization) on the following services to be performed by In & Out-of-Network Providers

*In order to avoid denial of services for Hospital/medical Benefits please call before receiving services or no later than two (2) business days, or as soon as reasonably possible, after admission for an emergency admission.

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

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

Late Notice
For In Network Providers, there are no late notice penalties. For Out-of-Network Providers, penalty is 50% of eligible charges.

The services that require Prior Authorization are:

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

- **Outpatient Services**
  - Bone Growth Stimulator: Electrical or Ultrasound
  - BRCA Genetic Testing Program (Genetic testing for cancer susceptibility)
  - Breast Procedures; including Reconstructive Surgery, Implants, Reduction , Mastectomy for
  - Gynecomastia and other Breast Procedures
  - Cardiac transcatheter closure of patent foramen ovale and left atrial appendage for stroke prevention.
  - Cardiac ventricular septal defect transmyocardial/perventricular device closure
  - Cardiac resynchronization therapy for heart failure treatment
  - Cardio-reduction, partial left ventriculectomy
  - Cardioverter defibrillators, implantable (“ICD”) and wearable
  - Heart monitors, real-time remote
  - Capsule Endoscopy
  - Clinical Trials
  - Cochlear implants and auditory brainstem implants

- Communication/speech generating devices, augmentative and alternative ("ACC")
- Hearing aids, bone-anchored and implantable, middle ear
- Durable Medical Equipment, including insulin pumps and supplies
- Home Health Care Nutritional/Enteral Therapy
- Home Health Care; Home Infusion
- Hyperbaric oxygen therapy (systemic/topical)
- Specialty Medications/Injectable Medications
- Ankle replacement
- Bicompartmental Knee Arthroplasty
- Uterine fibroid ablation, MRI guided high intensity focused ultrasound
- Mandibular/maxillary (orthognathic) surgery
- Accidental Dental
- Oral Surgery
- Prosthesis, microprocessor controlled lower limb
- Prosthetic devices, myoelectric upper extremity
- Potentially Unproven Services (experimental/investigational are Exclusions)
- Cosmetic and reconstructive services of the head and neck; trunk and groin
- Cosmetic and reconstructive services, skin related
- Reduction mammaplasty
- Blepharoplasty, blepharoptosis repair, and brow lift
- Penile prosthesis implantation
- Sleep apnea, obstructive; oral, pharyngeal and maxillofacial surgical treatment
- Sleep apnea, obstructive, treatment in adults
- Nasal surgery for the treatment of obstructive sleep apnea ("OSA") and radiofrequency ablation of nasal turbinates for nasal obstruction with or without OSA
- Obstructive sleep apnea, treatment in adults
- Uvulopalatopharyngoplasty
- Spinal cord stimulators ("SCS"), implanted
- Spinal percutaneous procedures (vertebroplasty, kyphoplasty and sacroplasty)
- Spinal stenosis, implanted devices
- Spinal artificial intervertebral discs
- Spine and joints other than the knee, manipulation under anesthesia
- Spine surgery lumbar – laminectomy and fusion
- Sacral nerve stimulation as treatment of neurogenic bladder secondary to spinal cord injury
- Sacroiliac joint fusion
- Intervertebral discs, cervical artificial Yes
- Transplant evaluation, pre-determination, Inpatient admits
- Radiofrequency volumetric tissue reduction ("RFVTR") of the soft palate, uvula, or tongue base. Can be considered as coblation, somnoplasty
- Vagus nerve stimulation
- Varicose vein (lower extremity) treatment
- Radiation Therapy
- Outpatient Sleep Testing and Therapy Services

- **Behavioral Health Services**
  - Inpatient and Outpatient Mental Health/Substance Abuse (in-network/out-of-network) within 24 hours of admission. **Residential MH/SA is not covered.**

- **A.I.M. Specialty Health services**
  - Radiology Services (CT scan, CTA, MRA, MRI, PET Scan)
  - Cardiac Services (Echocardiography or Nuclear Cardiology)

*__Pre-Determination__ for Medical Necessity for coverage for additional items if a Member or Provider requests are available. Though not required, a pre-determination of Benefits is strongly recommended before incurring medical costs for certain services. The following are some examples of services, but not limited to:

- Oral Surgery
- Pre-Surgery/Pre-admission Testing
- Infertility Services
- Treatment by assistant surgeons or co-surgeons
- Treatment of TMJ
- Allergy testing
- Occupational therapy
- Speech therapy
- Physical therapy
- Reconstructive services

Ask your health care Provider to submit a request for a pre-determination of Benefits. The request should clearly indicate that it is for pre-determination of Benefits.

Your Provider should contact BCBSGa or submit a written request to BCBSGa at the address on your ID card. The request should include a complete description of the proposed course of treatment, appropriate medical code, anticipated date of services and tax identification number of the service Provider.

BCBSGa will review the Predetermination request and determine eligibility of services.

BCBSGa will send a written response to your health care Provider and to you indicating whether the services are considered eligible expenses and/or whether the fees are within expense limits.

DISCLAIMER: The listing above requires that The BCBSGA Personal Health Coach Team be notified. Members must obtain pre-certification from BCBSGa for In and Out-of-Network services. Read your SPD carefully regarding Covered Services. If you are in doubt about whether a service is covered and requires pre-certification, please call Customer Service at 1-855-641-4862. It is your responsibility to notify BCBSGa of certain services and obtain pre-certification. Non-Prior Authorization could result in reduction in payment or non-payment. For In Network Providers, there are no late notice penalties. For Out-of-Network Providers, penalty is 50% of eligible charges. Prior authorization does not guarantee eligibility or payment.

VOLUNTARY INCENTIVE PROGRAM

AIM Imaging Cost & Quality Program

The Plan has selected this innovative Imaging Cost & Quality Program for Members through AIM Specialty Health. This Program provides you with access to important information about imaging services you might need.

If you need an MRI or a CT scan, it is important to know that costs can vary depending on where you receive the service. Sometimes the difference is significant. The cost can range anywhere from $300 to $3000(a higher price doesn't guarantee higher quality). Your Benefits require you to pay a portion of this cost (a Deductible or Coinsurance) so where you go can make a big difference in your out-of-pocket costs.

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

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

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

Individual Case Management

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Medical Claims Administrator's programs coordinate Benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Case Management programs are confidential and voluntary. These programs are provided at no extra cost to you.

If you meet program criteria and agree to take part in, the Medical Claims Administrator will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers.

In addition, the Medical Claims Administrator may assist with coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

How the HRA Plan Works for Medical Benefits

The HRA offers you a different approach for managing your health care needs. SHBP funds dollars to your HRA to provide first dollar coverage for eligible health care and pharmacy expenses. The HRA dollars are also used to reduce the Deductible and Out-of-Pocket Maximum. After satisfying your Deductible, you will pay your Coinsurance amount until you reach your Out-of-Pocket Maximum. Outpatient pharmacy costs do not apply to the Deductible or Out-of-Pocket Maximum.

HRA consists of three components:

1. HRA is funded by the SHBP and maintained by BCBSGa.

SHBP contributes money to your HRA account. These dollars are used to help pay for your covered medical expenses, like office visits, lab work and tests. It's important to note that when you go to the Doctor, you don't pay a Coinsurance at the time of the office visit. You should wait until the claim has been processed. Instead, you pay the contracted or discounted rate for service, even if the In-Network Provider charges more. If you don't use all of the money in your HRA account, it rolls over from year to year, as long as you remain enrolled in a HRA plan option.

Tier	Gold HRA Dollars	Gold HRA after completion of all 2014incentive actions (initial HRA $ + earned HRA $)	Silver HRA Dollars	Silver HRA after completion of all 2014incentive actions (initial HRA $ + earned HRA $)	Bronze HRA Dollars	Bronze HRA after completion of all 2014incentive actions (initial HRA $ + earned HRA $)
You	$400	$880	$200	$680	$100	$580
You + Child(ren)	$600	$1,080	$300	$780	$150	$630
You + Spouse	$600	$1,560	$300	$1,260	$150	$1,110
You + Family	$800	$1,760	$400	$1,360	$200	$1,160

SHBP Members will have access to a variety of Healthways tools, activities and services. To learn more, visit

www.BeWellSHBP.comSHBP.com beginning January 1, 2014.

2. Annual Deductibles and Coinsurance

You are responsible for paying annual Deductibles before the Plan begins to pay a percentage of your covered expenses. The money in your HRA account is used to help meet your Deductibles. If you've been enrolled in the plan for more than one year, you may have enough saved to pay for your entire Deductible. After you meet your annual Deductible, you pay a percentage of the cost of your covered expenses, called coinsurance. If you still have money in your HRA account after you've met your annual Deductible, you can use the funds to pay your share of coinsurance. Once you reach your annual coinsurance maximum, the plan pays 100 percent of any covered medical expenses for the rest of the year.

Note: There are separate Deductibles and Out-of-Pocket Maximums for in-network and out-of network expenses.

3. Health Information, online tools and support Members have access to Blue Cross Blue Shield and Express Script online tools to have a better idea of what their medical and pharmacy costs will be.

Your Health Reimbursement Account

- The HRA dollars placed in your Health Reimbursement Account will depend on the option selected. For example if enrolled in the Bronze Option at the beginning of the Plan year in the single tier, SHBP will fund $100.00 in this account.
- If you are a new hire or newly enrolled in the HRA Option within the plan year, the funds in your HRA will be pro-rated based on the number of months remaining in the plan year. The Deductible and Out-of-Pocket Maximum are not pro-rated.
- If you experience a qualifying event and increase your coverage tier, your new HRA dollars will be pro-rated based on the number of months remaining in the plan year.
- If you experience a qualifying event and decrease your coverage tier, the amount placed in your HRA for that plan year will not change.
- If you or an enrolled Dependent(s) experience a qualifying event which results in coverage under a new contract, the entire Deductible and Out-of-Pocket Maximum under the new contract will have to be met. All HRA balances, Deductibles and Out-of-Pocket Maximums will remain with the prior contract. Pro-rated HRA dollars will be deposited into the new contract based on the elected coverage tier and months remaining in the current plan year. Deductibles and Out-of-Pocket Maximums are not pro-rated.
- If your employment terminates for any reason, the funds in your HRA will revert back to the SHBP, unless you elect COBRA coverage and remain under the same contract. See the Eligibility & Enrollment document for COBRA coverage details. The HRA funds will remain available to assist you in paying your out-of-pocket costs while COBRA coverage is in effect.

Requesting Reimbursement From Your HRA

You must submit a request for reimbursement of any medical expenses no later than March 31 following the end of the Plan Year in which you are covered under this Plan. If you don't provide this information to us within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. This time limit does not apply if you are legally incapacitated.

If You Receive Covered Health Services from an In-Network Provider

When you receive covered health services from an In-Network Provider, the funds in your HRA may be used to help you meet your Calendar Year Deductible under your medical plan. Once the Calendar Year Deductible is met, you are responsible for the difference between the amount of Covered Services the medical plan pays and the total Maximum Allowed Amount, including any Coinsurance which is the amount and any non-Covered Services. Any funds left in your HRA may be used to assist you in paying this difference.

Filing a Claim for Out-of-Network Benefits

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

Required Information for Filing a Out-of-Network Claim

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

Note: Members and/or covered spouses can earn additional dollars for their HRA account. Healthways will administer the 2014 action-based HRA incentives. To earn these HRA dollars complete the following requirements anytime between January 1- December 31, 2014:

PLEASE SEE SHBP HRA CHART

SHBP HRA CHART

	What to DO	What you EARN
1	**Assess Your Health** Complete your Healthways Well-Being Assessment® (WBA), a confidential, online questionnaire that will take about 20 minutes.	Complete both and earn **$240** for your HRA account (WBA must be completed before HRA dollars can be earned)
2	**Know Your Numbers** Complete a biometric screening and submit results (body mass index, blood pressure, cholesterol, glucose). The biometric screening must be completed at an SHBP-sponsored screening event or by your physician or other providers identified by SHBP in published materials and your results submitted appropriately.	
3	**Take Action** It's your choice! Complete the coaching pathway, online pathway or a combination of both. **Coaching Pathway** Create your Well-Being Plan. Actively engage in telephonic coaching. **Online Pathway** Create your Well-Being Plan. Record 5 online well-being activities using the same tracker within 4 consecutive weeks and earn $40 into your HRA account. You can earn these HRA dollars ($40) up to 6 times. Sample activities: track exercise five times, record daily steps five times, track food five times.	Earn up to **$240** for your HRA account (WBA must be completed before HRA dollars can be earned)

Remember, Members and covered spouses who met the 2013 Wellness Requirements will receive their $240 HRA dollars in January 2014. This is in addition to the $480 HRA dollars each Member and their covered spouse, if applicable, can earn in 2014. For more information, see the Healthways Section of this SPD and/or visit www.BeWellSHBP.comSHBP.com.

What's Covered

This Section describes the Covered Services available under your Plan. Your Covered Services are subject to all the terms and conditions listed in this SPD, including, but not limited to, Benefit Maximums, Deductibles, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "**Schedule of Benefits**" Section for details on the amounts you must pay for Covered Services, and for details on any Benefit Maximums. Also, be sure to read the "**How Your Plan Works**" Section for more information on your Plan's rules. Read the "**What's Not Covered**" Section for important details on Excluded Services.

Your Benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several Sections may apply to your claims. For example, if you have a surgery, Benefits for your Hospital stay will be described under "**Inpatient Hospital Care**," and Benefits for your Doctor's services will be described under "**Inpatient Professional Service**". As a result, you should read all the Sections that might apply to your claims.

You should also know that many of the Covered Services can be received in several settings including: (i) a Doctor's office, (ii) an Urgent Care Facility, (iii) an Outpatient Facility, or (iv) an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services. This can result in a change in the

amount you will need to pay. Please see the "**Schedule of Benefits**" Section for more details on how Benefits vary in each setting.

Allergy Services

Your Plan includes Benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick /injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

- For ground ambulance, you are taken:
  - From your home, the scene of accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Medical Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Medical Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
  - Between a Hospital and an approved Facility.

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Autism Services

Your Plan includes coverage for the treatment of neurological deficit disorders.

Behavioral Health Services

See "**Mental Health and Substance Abuse Services**" later in this Section.

Cardiac Rehabilitation

Please see "**Therapy Services**" later in this Section.

Chemotherapy

Please see "**Therapy Services**" later in this Section.

Chiropractic Services

Benefits are available for chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.
Benefits do not include the following:

1. Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning, and prevents loss of that functioning, but which does not result in any additional improvement.
2. Nutritional or dietary supplements, including vitamins.
3. Cervical pillows.
4. Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in subsections below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your Benefits.

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

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

i. The Investigational item, device, or service, itself; or

ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Cancer Clinical Trial Programs for Children

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

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

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

Oral Care

Reconstructive surgical procedures (including dental implants) for the repair of sound, natural teeth or tissue that were damaged as a result of oral cancer or treatment for oral cancer such as chemotherapy or radiation treatment and other cancer related treatments with prior approval by the Precertification unit.

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Other Dental Services

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

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

Diabetes Equipment, Education, and Supplies

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

Diabetes self-management training is covered for an individual with insulin Dependent diabetes, non-insulin Dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

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

For the purposes of this provision, a "health care professional" means the Physician or podiatrist ordering the training, or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

For information on equipment and supplies, please refer to the "**Medical Supplies, Durable Medical Equipment, and Appliances**" provision in this Section. For information on Prescription Drug coverage, please refer to the "**Prescription Drugs**" Section in this SPD.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Dialysis

See "**Therapy Services**" later in this Section.

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

Durable Medical Equipment and Medical Devices

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

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

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

the cost of simply purchasing the equipment. Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Your Plan includes Benefits for prosthetics and durable medical equipment and medical supplies for the treatment of diabetes. Your plan also includes Benefits for breast pumps as described in the "**Preventive Care**" Section.

Benefits include hearing aids as stated in the "**Schedule of Benefits**".

Orthotics

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

Prosthetics

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

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

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs needed after cancer treatment, limited to the maximum shown in the "**Schedule of Benefits**".

Medical and Surgical Supplies

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

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products (unless they are received from a

community source, such as a blood donated through a blood bank).

Emergency Care Services

Emergency Services

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

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition" means a medical condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's health in serious danger or, for a pregnant woman placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include, but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns, cuts, uncontrolled bleeding, seizures, and such other acute condition as may be determined to be Emergencies by the Medical Claims Administrator.

Emergency Care

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

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

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

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

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

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor call the Medical Claims Administrator as soon as possible. The Medical Claims Administrator will review your care to decide if a Hospital stay is needed and how many days you should stay. See "**Getting Approval for Benefits**" for more details. If you or your Doctor fail to call the Medical Claims Administrator, you may

have to pay for services that are determined to be not Medically Necessary. Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless the Medical Claims Administrator agrees to cover it as an Authorized Service.

Home Care Services

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

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services.
- Diagnostic services.
- Nutritional guidance.
- Training of the patient and/or family/caregiver.
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. Other organizations may give services only when approved by the Medical Claims Administrator and their duties must be assigned and supervised by a professional nurse on the staff of the home health care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home).
- Medical supplies.
- Durable medical equipment.

Home Infusion Therapy

See "**Therapy Services**" later in this Section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

1. Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
2. Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
3. Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.

4. Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
5. Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
6. Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, (both before and after the Member's death). Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

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

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

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

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney), are covered like any other surgery under the regular Inpatient and outpatient Benefits described elsewhere in this SPD.

In this Section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

As decided by the Medical Claims Administrator, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions (including necessary acquisition procedures, mobilization, harvest and storage). It also, includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Prior Approval and Precertification

To maximize your Benefits, you should call the Medical Claims Administrator's Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. They will help you maximize your Benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if you are given a prior approval for the Covered Transplant Procedure, you or your Provider must call the Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before the Plan will cover Benefits for a transplant. Your Doctor must certify, and the Medical Claims Administrator must agree, that the transplant is Medically Necessary. Your Doctor

should send a written request for Precertification to the Medical Claims Administrator as soon as possible to start this process. Not getting Precertification will result in a denial of Benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity, and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered Members under this Plan, each will get Benefits under their plan.

- When the person getting the organ is a covered Member under this Plan, but the person donating the organ is not, Benefits under this Plan are limited to Benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

- If a covered Member under this Plan is donating the organ to someone who is not a covered Member, Benefits are not available under this Plan.

Transportation and Lodging

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

For lodging and ground transportation Benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code.

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

1. Child care,
2. Mileage within the medical transplant Facility city,
3. Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Medical Claims Administrator,
4. Frequent Flyer miles,

5. Coupons, Vouchers, or Travel tickets,
6. Prepayments or deposits,
7. Services for a condition that is not directly related, or a direct result, of the transplant,
8. Phone calls,
9. Laundry,
10. Postage,
11. Entertainment,
12. Travel costs for donor companion/caregiver,
13. Return visits for the donor for a treatment of an illness found during the evaluation,
14. Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Infertility Services

Please see "**Maternity and Reproductive Health Services**" later in this Section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for a private room is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation, and no isolation facilities are available.
- A room in a special care unit approved by the Medical Claims Administrator. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.

- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

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

Maternity and Reproductive Health Services

Maternity

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

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

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

Important Note About Maternity Admissions: Under federal law, the Plan may not limit Benefits for any Hospital length of stay for childbirth, for the mother or newborn to: less than 48 hours after vaginal

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

Contraceptive Benefits

Benefits are available for contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "**Preventive Care**" benefit. Please see that Section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "**Preventive Care**" benefit.

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life of the mother.

Infertility Services

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Important Note: This Plan does not offer any form of infertility treatment. Non-covered service includes assisted reproductive technologies (ART) or the diagnostic tests and Prescription Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT). Fertility treatments such as artificial insemination and in-vitro fertilization, egg and sperm storage/preservation for future pregnancy are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient Benefits include psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation.
- **Outpatient Services** including treatment in an outpatient department of a Hospital and office visits.
- **Day Treatment Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.

You can get Covered Services from the following Providers:

- Psychiatrist,

- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse Specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed to give these services, when they must be covered by law.

Nutritional Counseling

Covered Services include nutritional counseling visits when referred by your Doctor as indicated in the **Schedule of Benefits**.

Occupational Therapy

Please see "**Therapy Services**" later in this Section.

Office Visits and Doctor Services

Covered Services include:

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

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

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

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

Urgent Care as described in the "Urgent Care Services" later in this Section.

Prescription Drugs Administered in the Office

Orthotics

See "**Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies**" earlier in this Section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

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

Physical Therapy

Please see "**Therapy Services**" later in this Section.

Preventive Care

Preventive Care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed heath problem will get Benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Certain Preventive care services are covered with no Deductible or Coinsurance when you use an In-Network Provider and the service is properly coded as preventive care. That means the Plan covers 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
    a. Breast cancer,
    b. Cervical cancer,
    c. Colorectal cancer,
    d. High blood pressure,

e. Type 2 Diabetes Mellitus,

f. Cholesterol,

g. Child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

   a. Women's contraceptives, sterilization procedures and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs) and implants.

   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.

   c. Gestational diabetes screening.

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

http://www.ahrq.gov/clinic/uspstfix.html,
http://www.healthcare.gov/center/regulations/prevention.html, and
http://www.cdc.gov/vaccines/recs/acip/.

Covered Services also include the following services required by state and federal law:

- Lead poisoning screening for children.
- Routine mammograms.
- Appropriate and necessary childhood immunizations that meet the standards approved by the U.S. public health service for such biological products against at least all of the following:
  - Diphtheria,
  - Pertussis,
  - Tetanus,
  - Polio,
  - Measles,
  - Mumps,
  - Rubella,
  - Hemophilus influenza b (Hib),

- Hepatitis B,
- Varicella.

(Additional immunizations will be covered per federal law, as indicated earlier in this Section.)

- Routine colorectal cancer examination and related laboratory tests.
- Chlamydia screening.
- Ovarian surveillance testing.
- Pap smear.
- Prostate screening.

Prosthetics

See "**Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies**" earlier in this Section.

Pulmonary Therapy

Please see "**Therapy Services**" later in this Section.

Radiation Therapy

Please see "**Therapy Services**" later in this Section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

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

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Respiratory Therapy

Please see "**Therapy Services**" later in this Section.

Skilled Nursing Facility

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

Speech Therapy

Please see "**Therapy Services**" later in this Section.

Surgery

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

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

Oral Surgery

Important Note: Although this Plan provides coverage for certain oral surgeries, many types of oral surgery procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

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

Reconstructive Surgery

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

Note: **This Section does not apply to orthognathic surgery. See the "**Oral Surgery**" Section above for that benefit.**

Mastectomy Notice

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

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures). See "Schedule **of Benefits**" of the benefit maximums.

Therapy Services

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints

of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Early Intervention Services

Physical, Occupational and Speech Therapy

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

For all other Members (e.g., those six (6) and older, or who do not qualify for the Benefits above), Benefits are provided only if the physical, speech or occupational therapy will result in a practical improvement in the level of functioning within a reasonable period of time and the physical, speech or occupational therapy must be Medically Necessary. Benefits for physical, speech or occupational are allowed up to the maximum visits listed in the "**Schedule of Benefits**".

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the Section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy**– Nursing, durable medical equipment and Prescription Drug services that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the Section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.

- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Prescription Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See "**Human Organ and Tissue Transplant**" earlier in this Section.

Urgent Care Services

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

Benefits for urgent care include:

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

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "**Preventive Care**" benefit.

Benefits do not include glasses and contact lenses except as listed in the "**Prosthetics**" benefit.

Drugs Administered by a Medical Provider

Your Plan covers Drugs when they are administered to you as part of a Doctor's visit, home care visit, or at an outpatient Facility. This includes drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This Section applies when your Provider orders the drug and administers it to you.

Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by BCBSGa. The Prescription Drugs Benefits which include retail, mail order and specialty drug programs are administered by Express Scripts. See the Pharmacy Benefits Section of the SPD.

Important Details About Prescription Drug Coverage

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

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. The Medical Claims Administrator will contact your Provider to get the details needed to decide if Prior Authorization should be given. The Medical Claims Administrator will give the results of its decision to both you and your Provider.

If Prior Authorization is denied for a Prescription Drug paid under your medical benefit, you have the right to file an Appeal (Grievance) as outlined in the "**Your Right To Appeal**" Section of this SPD.

For a list of Prescription Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a drug or related item on the list does not promise coverage under your Plan. Your Provider may check with the Medical Claims Administrator to verify drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand name or Generic drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of drug before the Plan will cover another. The Medical Claims Administrator checks certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. The Medical Claims Administrator may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. The Medical Claims Administrator has a therapeutic drug substitutes list, which is reviewed and updated from time to time. For questions or issues about therapeutic drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Disease Management (DM) Coinsurance Waiver Program

Blue Cross Blue Shield of Georgia (BCBSGa) and Express Scripts (ESI) have a disease management Prescription Drug Coinsurance waiver program. Pharmacy cost shares for specific Prescription Drugs will be waived for State Health Benefit Plan (SHBP) Members for those Members actively participating in the DM. The goal is to encourage Members to actively work on managing their condition and their overall health.

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

- Diabetes
- Coronary Artery Disease
- Asthma

Member must actively participate in a care management program, as confirmed by the BCBSGa Personal Health Coach (PHC), and complete the following:

✓ Complete the Health Information Profile (assessment) with a BCBSGa Personal Health Coach.

✓ Complete the Healthways Well-Being Assessment (Healthways is an external vendor providing Lifestyle Management Coaching to SHBP Members. The Well-Being Assessment® is a confidential, online questionnaire that will take the Member about 20 minutes to complete).

✓ Actively participate in scheduled coaching calls with a Personal Health Coach (minimum 1 call each calendar month).

If you have Diabetes, Asthma and/or CAD and are interested in participating in the Personal Health Coach Program and learning more about how to qualify for the Coinsurance Waiver incentive, please call Customer Service toll-free at: 1-855-641-4862.

What's Not Covered

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

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

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

3. **Administrative Charges**
   a) Charges for the completion of claim forms,
   b) Charges to get medical records or reports,
   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
4. **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a) Acupuncture,
   b) Holistic medicine,
   c) Homeopathic medicine,
   d) Hypnosis,
   e) Aromatherapy,
   f) Massage and massage therapy,
   g) Reiki therapy,
   h) Herbal, vitamin or dietary products or therapies,
   i) Naturopathy,
   j) Thermography,
   k) Orthomolecular therapy,
   l) Contact reflex analysis,
   m) Bioenergial synchronization technique (BEST),
   n) Iridology-study of the iris,
   o) Auditory integration therapy (AIT),
   p) Colonic irrigation,
   q) Magnetic innervation therapy,
   r) Electromagnetic therapy,
   s) Neurofeedback / Biofeedback.
5. **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
6. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
7. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
8. **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.

9. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No Benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or surgery to restore function of anybody area that has been altered by illness or trauma.
10. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
11. **Crime** Treatment of injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if you were the victim of a crime, including domestic violence.
12. **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
13. **Dental Treatment** Dental treatment, except as listed below.

    Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as:

    - Removing, restoring, or replacing teeth;
    - Medical care or surgery for dental problems (unless listed as a Covered Service in this SPD);
    - Services to help dental clinical outcomes.

    This Exclusion does not apply to services that must be covered by law.
14. **Dental Services –** Dental services not described as Covered Services in this SPD.
15. **Educational Services** or supplies for teaching, vocational, or self training purposes, including Applied Behavior Analysis (ABA), except as listed in this SPD.
16. **Experimental or Investigational Services** or supplies that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Medical Claims Administrator deems it to be Experimental / Investigative.
17. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight. This Exclusion does not apply to lenses needed after a covered eye surgery.
18. **Eye Exercises** Orthoptics and vision therapy.
19. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
20. **Family Members** Services prescribed, ordered, referred by or given by a Member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
21. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

    a) Cleaning and soaking the feet.

b) Applying skin creams to care for skin tone.

c) Other services that are given when there is not an illness, injury or symptom involving the foot.

22. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.

23. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

24. **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If Worker's Compensation Benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the Benefits in whole or in part. This Exclusion also applies whether or not you claim the Benefits or compensation, and whether or not you get payments from any third party.

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

26. **Home Care**

    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a home health care Provider.

    b) Food, housing, homemaker services and home delivered meals.

27. **Infertility Treatment** Testing or treatment related to infertility except for diagnostic services and procedures to correct an underlying medical condition. Other Infertility procedures not specified in this SPD.

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

29. **Medical Equipment and Supplies**

    d) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

    e) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

    f) Non-Medically Necessary enhancements to standard equipment and devices.

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

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

32. **Non–Covered Providers** Examples of Non-Covered providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.
33. **Non-Medically Necessary Services** the Medical Claims Administrator concludes are not Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
34. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this SPD or that must be covered by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.
35. **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this SPD.
36. **Personal Care and Convenience**
    a) Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs;
    b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads);
    c) Home work out or therapy equipment, including treadmills and home gyms;
    d) Pools, whirlpools, spas, or hydrotherapy equipment;
    e) Hypo-allergenic pillows, mattresses, or waterbeds; or
    f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
37. **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy.
38. **Private Duty Nursing** Private Duty Nursing Services.
39. **Prosthetics** for sports or cosmetic purposes.
40. **Routine Physical Exams** Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, or for school activities.
41. **Residential Treatment Centers** Unless required to be covered by law.
42. **Sex Change** Services and supplies for a sex change, gender reassignment and/or the reversal of a sex change.
43. **Sexual Dysfunction** Services or supplies for male or female sexual problems.
44. **Smoking Cessation Programs** to help you stop smoking if the program is not affiliated with BCBSGa or Healthways (the SHBP Wellness vendor).
45. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
46. **Sterilization** Reversals of elective sterilizations are not covered. This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that Section for further details.

47. **Surrogate Mother Services** or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
48. **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
49. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
50. **Vein Treatment** of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
51. **Vision Services** Vision services not described as Covered Services in this SPD.
52. **Weight Loss Programs**, whether or not under medical supervision, unless listed as covered in this SPD.

    This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
54. **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partially digested food from the duodenum to the jejunum, the Section of the small intestine extending from the duodenum), or gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

Claims Payment

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

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

Maximum Allowed Amount

General

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

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

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

When you receive Covered Services from an eligible Provider, the Medical Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. The application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Medical Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, the Maximum Allowed Amounts may be reduced for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network or an Out-of-network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific Plan or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the Medical Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit: www.bcbsga/shbp.com.

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

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

1. An amount based on the Medical Claims Administrator Out-of-network fee schedule/rate, which the Medical Claims Administrator has established in its discretion, which the Medical Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: (i) reimbursement amounts accepted by like/similar Providers contracted with the Medical Claims Administrator; (ii) reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, and (iii) reimbursement and utilization data.

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Medical Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually.

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

4. An amount negotiated by the Medical Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

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

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

Customer Service is also available to assist you in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although

Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider. For Out-of-Network Providers, the plan does not accept assignment of Benefits. You will receive a payment of Benefits and it will be your responsibility to pay that to the Out-of-Network Provider.

Member Cost Share

For certain Covered Services, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, and/or Coinsurance).

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

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact the Medical Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact the Medical Claims Administrator until after the Covered Service is rendered. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an, Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider "s charge. Please contact Customer Service to obtain authorization or to request information on Authorized Services.

Notice of Claim & Proof of Loss

After you get Covered Services, the Medical Claims Administrator must receive written notice of your claim within twelve (12) months in order for Benefits to be paid. The claim must have the information needed to determine Benefits. If the claim does not include enough information, the Medical Claims Administrator will ask for more details and it must be sent in order for Benefits to be paid, except as required by law. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information.

In certain cases, you may have some extra time to file a claim. If the Medical Claims Administrator did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the ninety (90) day period ends (i.e., within fifteen (15) months), you may still be able to get Benefits. **However, any claims, or additional information on claims, sent in more than twenty-four (24) months after you get Covered Services will be denied.**

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

Medical Claim Forms

Medical claim forms will usually be available from most Providers. If forms are not available, visit BCBSGa website at: www.bcbsga/shbp.com or contact your local Human Resources Department or Customer Service and ask for a claim form to be sent to you. If you do not receive the claim form, written notice of services rendered may be submitted without the medical claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Payment of Benefits

The Medical Claims Administrator may make benefit payments directly to In-Network Providers for

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

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

Out-of-Area Services

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

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

BCBSHP covers only limited healthcare services received outside of BCBSHP's corporate parent's service area. As used in this Section, "**Out-of-Area Covered Healthcare Services**" include emergency and urgent care obtained outside the geographic area BCBSHP's corporate parent serves. Other services will not be covered when processed through any Inter-Plan Programs arrangements.

BlueCard® Program

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

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

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

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

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

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

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

Non-Participating Healthcare Providers Outside The Medical Claims Administrator's Service Area

Member Liability Calculation

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

Exceptions

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

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

Coordination of Benefits When Members Are Insured Under More Than One Plan

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

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

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

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

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

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

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

This Plan means the part of this Plan that provides Benefits for health care expenses.

Primary Plan/Secondary Plan means the **"Order of Benefit Determination Rules"** Section states whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering you. When This Plan is a Secondary Plan, its Benefits are determined after those of the other plan and may be reduced because of the other plan's Benefits.

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

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

Order of Benefit Determination Rules

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

- Automobile Insurance

  Medical Benefits available through automobile insurance coverage will be determined before this Plan.

- Non-Dependent/Dependent

  The Benefits of the program which covers the person as a Covered Person (other than as a Dependent) are determined before those of the program which covers the person as a Dependent.

- Dependent Child/Parents Not Separated or divorced

  Except as stated below, when this program and another program cover the same child as a Dependent of different persons, called "parents":

  - The Benefits of the program of the parent whose birthday falls earlier in a year are determined before those of the program of the parent whose birthday falls later in that year.
  - If both parents have the same birthday, the Benefits of the program which covered the parent longer will be determined before those of the program which covered the other parent for a shorter period of time.

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

- Dependent Child/Parents Separated or Divorced

  If two or more programs cover a person as a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:

  - the program of the parent with custody of the child;
  - the program of the spouse of the parent with custody of the child; and
  - the program of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company obligated to pay or provide the Benefits of the program of

that parent has actual knowledge of those terms, the Benefits of that program are determined first. This paragraph does not apply with respect to any claim determination period or program year during which any Benefits are actually paid or provided before the company has that actual knowledge. Joint Custody

If the specific terms of a court decree state that the parents shall have joint custody, (without stating that one of the parents is responsible for the health care expenses of the child), the programs covering the child shall follow the order of benefit determination rules outlined above for "**Dependent Child/Parents not Separated or Divorced**."

- Active/Inactive Covered Person

  The Benefits of a program that covers a person as a Covered Person who is neither laid off nor retired (or as that Covered Person's Dependent) are determined before those of a program that covers that person as a laid-off or retired Covered Person (or as that Covered Person's Dependent). If the other program does not have this rule, and if, as a result, the programs do not agree on the order of Benefits, this rule is ignored.

- Longer/Shorter Length of Coverage

  If none of the above rules determine the order of Benefits, the Benefits of the program which covered a Covered Person or Member longer are determined before those of the program that covered that person for the shorter time.

Effect on the Benefits of This Plan

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

Reduction in this program's Benefits

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Reimbursement

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

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

Subrogation and Reimbursement

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

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

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

Your Duties

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

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, the Medical Claims Administrator is committed to making sure your rights are respected while providing your health Benefits. That also means giving you access to the Medical Claims Administrator's Network Providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

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

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health Benefits or ask for

help if you need it.

- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician (Doctor), also called a PCP.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.
- Give the Medical Claims Administrator, your Doctors and other health care professionals the information needed to help you get the best possible care and all the Benefits you are entitled to. This may include information about other health and insurance Benefits you have in addition to your coverage with the Plan.
- Let the Medical Claims Administrator's customer service department know if you have any changes to your name, address or family Members covered under your Plan.

The Medical Claims Administrator is committed to providing quality Benefits and customer service to its Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact the Medical Claims Administrator, please go to www.bcbsga/shbp.com or call the Member Services number on the back of your ID card.

Your Right To Appeal

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

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

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

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

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

Notice of Adverse Benefit Determination

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

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

For claims involving urgent/concurrent care:

- The Medical Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process.

- The Medical Claims Administrator may notify you or your authorized representative within seventy-two (72) hours orally and then furnish a written notification.

Appeals (Grievances)

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

- The Medical Claims Administrator shall offer a single mandatory level of appeal and a mandatory second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Medical Claims Administrator to complete its review is Dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Medical Claims Administrator's decision, can be sent between the Medical Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Medical Claims Administrator at the number shown on the back of your identification card and provide at least the following information:

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

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

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

You must include your Member Identification Number when submitting an appeal.

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

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

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

For Out of State Appeals (Grievances) You have to file Provider Appeals with the Host Plan. This means Providers must file Appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Medical Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than seventy-two (72) hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Medical Claims Administrator will notify you of the outcome of the appeal within 15 days after receipt of your request for appeal.

If you appeal a post-service claim, the Medical Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

Appeal Denial

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

Mandatory Second Level Appeals (Grievances)

If you are dissatisfied with the Plan's mandatory first level appeal decision, a mandatory second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Second Level Appeals (Grievances) must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a mandatory second level appeal prior to submitting a request for an independent External Review.

External Review

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

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

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

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

All other requests for External Review should be submitted in writing unless the Medical Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be

submitted by you or your authorized representative to:

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

You must include your Member Identification Number when submitting an appeal.

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

Requirement to file an Appeal before filing a lawsuit

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

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

Termination and Continuation of Coverage

General Provisions

Form or Content of SPD

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

Government Programs

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

Medical Policy and Technology Assessment

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

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

Medicare

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

Except when federal law requires the Plan to be the primary payor, the Benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the Plan, to the extent that payment was made for such services. For the purposes of the calculation of Benefits, if you have not enrolled in Medicare Parts B and/or D the Medical Claims Administrator will pay primary Benefits and Covered Person will pay the unsubsidized premium. **You should enroll in Medicare Part B as soon as possible to avoid paying the unsubsidized rates.**

Governmental Health Care Programs

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

Modifications

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

Not Liable for Provider Acts or Omissions

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

Policies and Procedures

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

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

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

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

Plan Administrator's Sole Discretion

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

Reservation of Discretionary Authority

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

Right of Recovery

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

The Medical Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Plan Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. The Medical Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Medical Claims Administrator may not give you notice of overpayments made by the Plan or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your 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.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Value of Covered Services

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

Waiver

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

Workers' Compensation

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

Medical Definitions

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

Accidental Injury

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

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

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

Appeals (Grievance)

Please see the "**Your Right To Appeal**" Section.

Authorized Service(s) for Out-Of-Network Providers

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

Benefits

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

Benefit Period

The length of time that the Plan will cover Benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period begins on your Plan's effective or renewal date and lasts for 12 months. The "**Schedule of Benefits**" shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

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

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have a Center of Excellence Agreement with the Medical Claims Administrator.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "**Schedule of Benefits**" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Covered Person

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

Covered Services

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

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

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in the "**Termination and Continuation of Coverage**" Section.

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

Custodial Care

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

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

1. Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
2. Changing dressings of non-infected wounds, after surgery or chronic conditions,
3. Preparing meals and/or special diets,
4. Feeding by utensil, tube, or gastrostomy,
5. Common skin and nail care,
6. Supervising medicine that you can take yourself,
7. Catheter care, general colostomy or ileostomy care,
8. Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
9. Residential care and adult day care,
10. Protective and supportive care, including education,
11. Rest and convalescent care.

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

Deductible

The amount you must pay for Covered Services before Benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "**Schedule of Benefits**" for details.

Dependent

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

Doctor

See the definition of "**Physician**."

Effective Date

The date your coverage begins under this Plan.

Employee

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

Enrolled Member

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

Enrollment Date

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

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational

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

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

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

Facility

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

Health Plan or Plan

See definition of **The State Health Benefit Plan**.

Home Health Care Agency

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

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

Hospice

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

Hospital

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

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

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

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

Identification Card (ID Card)

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

In-Network Provider

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

Inpatient

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

Maximum Allowed Amount

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

Medical Claims Administrator

The company the Plan Sponsor chose to administer its medical health Benefits. Blue Cross and Blue Shield of Georgia, Inc. was chosen to administer certain medical Benefits of this Plan. The Medical Claims Administrator provides administrative claims payment services only.

Medical Necessity (Medically Necessary)

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

- 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 Doctor, health care Provider or Hospital;
- Not primarily Custodial Care;
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis; and
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

Member

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

Non-Covered Provider

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

Non-Preferred Provider

A Hospital, Freestanding Ambulatory Facility (Surgical Center), Doctor, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have a Point of Service Contract with Contract with the Medical Claims Administrator but is contracted with the Medical Claims Administrator's indemnity network. **Note**: **Out-of-Network Benefits apply when Covered Services are rendered by a Non-Preferred Provider.**

Out-of-Network Provider

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

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

Out-of-Pocket Maximum

The most you pay during a Benefit Period for Covered Services before your Plan begins Benefits. The Out-of-Pocket limit does not include your premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Limit may consist of Deductibles, and/or Coinsurance. Please see the "**Schedule of Benefits**" for details.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The State Health Benefit Plan.

Plan Year

January 1st to December 31st.

Plan Administrator

The Georgia Department of Community Health, SHBP Division. References to "we", "us", and "our" in this SPD are to the Department of Community Health, SHBP Division.
The Plan Administrator is not the Medical Claims Administrator.

Plan Sponsor

The Georgia Department of Community Health.
The Plan Sponsor is not the Medical Claims Administrator.

Precertification

Please see the Section "**Getting Approval for Benefits**" for details.

Predetermination

Please see the Section "**Getting Approval for Benefits**" for details.

Prescription Drug (Drug)

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

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

Primary Care Physician (—PCP)

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

Primary Care Provider

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

Prior Authorization

Please see the "**Getting Approval for Benefits**" and "Prescription Drugs Administered by a Medical Provider" Sections for details.

Provider

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

Recovery

Please see the "**Subrogation and Reimbursement**" Section for details.

Referral

Please see the "**How Your Plan Works**" Section for details.

Retail Health Clinic

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

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by regulatory agencies.

Skilled Nursing Facility

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

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

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

Special Enrollment

A period of time in which eligible people or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "**Eligibility and Enrollment**" Section for more details.

Specialist (Specialty Care Physician / Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

State Health Benefit Plan (SHBP)

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

Summary Plan Description (SPD)

This document. The SPD provides you with a description of your Benefits while you are enrolled under the Plan.

Urgent Care Center

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

Well-Being Incentives Programs

Introduction

Well- Being Program Description – Be Well SHBP

State Health Benefit Plan will be sponsoring Wellness Programs through a new Well-Being vendor, Healthways. For more than thirty (30) years, Healthways has empowered more than 38 million people worldwide to find what inspires them and achieve their personal best. The Healthways team will provide you with the support, tools and medical information you need to improve your own health and well-being.

The SHBP's **Be Well** Well-Being program offers a holistic approach to your personal Well-Being. By providing some of the most effective health resources and coaching services available, you and your covered spouse will be empowered to achieve your personal or family Well-Being goals and pursue a longer, healthier, and more fulfilled life.

New SHBP Web Portal - www.BeWellSHBP.comSHBP.com

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

Key components of Well-Being Connect include:

- **Live Chat:** Enables Members to directly outreach to a coach or Member services staff
- **Well-Being Plan:** The Well-Being Plan helps you reach your healthy best. Your answers to the Healthways Well-Being Assessment® (WBA) help gauge the focus areas you're most ready to act on and shape your personal Well-Being Plan.
- **Mobile Application and Smart Phone Technology: wellbeingGO** mobile app places the power of Well-Being Connect in the hands of smartphone users.
- **Health Trackers**: for medication adherence, exercise, healthy eating, personal tracker (allows Members to create their own tracker), steps program, tobacco cessation, and weight management.
- **Online Campaigns and Challenges:** The Groups and Challenges feature allows Members to interact with one another, or compete against one another in pre-defined challenges for walking (steps program), exercise, and weight loss.
- **Educational Tools and Information:** The portal pushes health information, articles and video segments to Members based on their Well-Being Plan, progress toward behavior change, and specified preferences. There is also a portal library that includes hundreds of articles on health and disease topics, healthy recipes, and meal plans.

- **Device integration to promote fitness, exercise and health and Well-Being.** Members using **Well-Being Connect** can link their own devices, such as a "Fitbit Ultra pedometer or Withings wi-fi scale," to the trackers in their personal plans. Once linked, the device will share its data with Well-Being Connect automatically, updating activity trackers. When a participant logs into Well-Being Connect, the data will populate from the device vendor (i.e., Fitbit) and use it to update the appropriate data points in your Well-Being Plan. Neither Healthways nor SHBP can assist with the use of the devices. Members are responsible for making sure that the information is properly tracked.
- Incentive Points and Rewards Tracking: The portal supports direct incentive tracking and shows real-time awards accumulation to each eligible Member. This tracker allows Members to see their incentive progress.

Family Centered Well-Being

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

Healthways Well-Being Assessment®

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

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

Telephonic Well-Being Coaching

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

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

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

Biometric Screenings

A Biometric Screening provides an excellent opportunity to know your numbers and what they mean for you. The screening typically takes 10-15 minutes. During a biometric screening event, a health professional will collect measurements, including Body Mass Index, Blood Pressure, Cholesterol and Glucose. In 2014, SHBP Members and covered spouses will have the opportunity to participate at an onsite SHBP sponsored event or at their personal Physician's office.

2014 Physician Screening Forms

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

If the 2014 Physician Screening Form submitted by your Physician is incomplete (i.e., missing pre-populated Member information, missing Physician signature or participant signature), your form will not be processed. In order to process your form and have your results loaded into the portal, you will need to work with your Physician's office to ensure that the form is signed and submitted by the deadline of December 31, 2014. If your form is signed, but only partially completed, your form will be processed as is and the portal will only show results for the data provided.

Health Reimbursement Arrangement Account Wellness Incentives

Starting this January 2014, SHBP Members and covered spouses can each earn up to $480 for their Health Reimbursement Arrangement (HRA) Account for participating and engaging in healthy activities - that is a family total of up to $960. HRA dollars can be used for eligible health care expenses with unused dollars rolling over to the next Plan Year if you keep HRA coverage (and remain an SHBP Member). The new 2014 action-based incentives will be earned as the action is completed and deposited in the HRA account monthly. To earn these dollars, complete the following between January and December 2014:

	What To Do	What You Earn
1.	**ASSESS YOUR HEALTH** Complete your Healthways Well-Being Assessment™® (WBA), a confidential, online questionnaire that will take about 20 minutes.	**Complete** BOTH **and earn** **$240** for your HRA account (*WBA must be completed before HRA dollars can be earned.*)
2.	**KNOW YOUR NUMBERS** Complete a biometric screening and submit results (body mass index, blood pressure, cholesterol, glucose). The biometric screening must be completed at an SHBP sponsored screening event or by your Physician or other Providers identified by SHBP in published materials.	

	What To Do	What You Earn
3.	**TAKE ACTION** It's your choice! Complete the coaching or online pathway or a combination of both. **COACHING PATHWAY** Create your Well-Being Plan. Actively engage in telephonic coaching. **ONLINE PATHWAY** Create your Well-Being Plan. Record 5 online well-being activities using the same tracker within 4 consecutive weeks and earn $40 into your HRA account. You can earn these HRA dollars ($40) up to 6 times. Sample activities: track exercise five times, record daily steps five times, track food servings five times.	**Earn up to $240** for your HRA account (*WBA must be completed before HRA dollars can be earned.*)

Members and covered spouses who met the 2013 Wellness Requirement will receive their $240 for their HRA in January 2014. This is in addition to the $480 HRA dollars each Member and spouse can earn in 2014.

*The 2014 action-based incentives do not apply to the Medicare Advantage Options.

Getting started:

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

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

HRA Incentive Tracking

Through the Well-Being Connect portal, Members can see up to date statuses regarding HRA Plan dollar awards. The HRA dollars will be available the month after completion of the activity. This includes completion of the Well-Being Assessment and biometric screening, enrollment and engagement in Well-Being coaching , and ongoing participation in the Well-Being Connect portal.

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

Timelines for Actions to be posted to your HRA Account

The Healthways Well-Being Assessment™® will be live on January 1, 2014. Immediately after taking the Well-Being Assessment® you will receive your Well-Being Assessment Report. Within 24 hours you will be invited back to the site to register and set up your Well-Being Plan. You have until December 31, 2014 to complete your Well-Being Assessment™®.

The 2014 action-based incentives will be earned as the action is completed and deposited in the HRA account monthly. If you complete a Telephonic Well-Being Coaching engagement call and an advising coaching call you will be awarded a total of $240 for your HRA account after setting up the Well-Being Plan.

When the biometric screening is completed at an SHBP sponsored screening event or by your Physician or other Providers identified by SHBP in published materials between January 2014 – December 2014 and the data is successfully completed as outlined within all documents, you will earn $240 for your HRA account if you also completed your Well-Being Assessment at www.BeWellSHBP.comSHBP.com or via paper.

If your HRA dollars are not properly displaying in the www.BeWellSHBP.comSHBP.com Reward Center portal, please call Healthways at 888-616-6411.

The below serves as examples of 2014 HRA dollars.

Member Experience #1:

Joe Phipps is enrolled as a single individual in the SHBP HRA Gold plan. He will automatically receive **$400** deposited into his HRA by enrolling in the Gold BCBSGa SHBP Medical Plan. In January, Joe logs onto www.BeWellSHBP.comSHBP.com and enters the Healthways Well-Being Connect portal. Joe completes his confidential online Well-Being Assessment. He goes to an onsite screening in February and earns an additional **$240** for his HRA. After completing his Well-Being Assessment he is invited back to Well-Being Connect portal and sets up his Well-Being Plan. In March, he is identified for telephonic Well-Being coaching and receives his initial engagement call. The engagement representative schedules a call with his coach within the next week at a time that is convenient for him. Joe then has a personal 1:1 telephonic coaching session with a Well-Being Coach. After completion of his coaching advising session Joe is awarded an additional **$240** for a total of incentive award total of **$480**. Joe has earned his total HRA dollars for 2014 and has a total of **$880** to assist with his Deductible.

Member Experience #2:

Mary Day is enrolled as a spouse of an employee enrolled in the SHBP HRA Gold plan. She and her spouse will automatically get **$600** deposited into their HRA. In January, Mary logs onto www.BeWellSHBP.comSHBP.com and enters the Well-Being Connect portal. Mary completes the confidential online Well-Being Assessment. Mary goes to her Physician in April for her annual physical. Her Physician completes the appropriate 2014 Physician Screening Form. Mary returns the form via fax per the instructions at www.BeWellSHBP.comSHBP.com and earns an additional **$240** for her HRA. After completing her Well-Being Assessment she is invited back to set up her Well-Being Plan. Mary completes the Well-Being Plan. In March, she starts training for her first 5k and starts tracking her training on the Well-Being Connect portal. After tracking her training within a four week period Mary earns **$40** for her HRA account. Four weeks later Mary continues to track her exercise and earns an

additional **$40**. In June, Mary completes her first 5k and decides to start tracking her food servings in hope to eat a healthier diet. Mary tracks her food servings 5 times in the next 4 week period and earns **$40** for her HRA account. Mary continues tracking food servings for several months and earns a total of **$240** for her HRA. Mary has earned a total of **$480** for her and her spouses HRA account.

Member Experience #3:

Mark Kelly is enrolled as a single individual in the SHBP HRA Gold plan. He will automatically get **$400** deposited into his HRA. In July, he logs onto www.BeWellSHBP.comSHBP.com and enters the Healthways Well-Being Connect portal and completes the confidential online Well-Being Assessment. Mark also completes his biometric screening at an onsite SHBP sponsored event in July. He is awarded an additional **$240** for his HRA for completing his Well-Being Assessment and biometric screening. In August, Mark decides to self-enroll in coaching and calls the Well-Being coaches at 1-888-616-6411. He completes an initial engagement call to learn more about the program. At that time, he is scheduled for a coaching session at a time that is convenient for him. The Well-Being coach outreaches to Mark at the scheduled time. Mark and the Well-Being coach discuss his goals and opportunities for health improvement. The Well-Being coach sets a goal with Mark to complete and set up his Well-Being Plan by their next scheduled call. Mark quickly completes this goal and sets up his Well-Being Plan. Mark is awarded an additional **$240** for his HRA for completing his coaching pathways. He receives a 2014 total of **$880** in HRA funds.

Member Experience #4:

Betty Jones is enrolled as a single individual in the SHBP HRA Gold plan. She will automatically get **$400** deposited into her HRA. In March, she completes the confidential Well-Being Assessment at www.BeWellSHBP.comSHBP.com in the Healthways Well-Being connect portal. Betty completed a Physician biometric screening in 2013 and doesn't complete a biometric screening in 2014. The total HRA dollars deposited in to her account is **$400**.

Member Experience #5:

Brian Cramer is enrolled as a single individual in the SHBP HRA Gold plan. He will automatically get **$400** deposited into his HRA. In February, a Be Well SHBP engagement representative calls Brian and tells him more about the telephonic coaching component of the program. Brain is excited about the program and schedules a call with a Well-Being coach in the next few days. The coach outreaches to Brian and they have a monthly call throughout 2014. Brian is not awarded any additional dollars for his HRA in 2014 as he has not completed the Well-Being Assessment and Well-Being Plan.

Please refer to your medical summary for more information about HRA.

Health Reimbursement Arrangement Incentive Appeals

Rights under all 2014 SHBP HRA Plan. Provided by Healthways SHBP's Well-Being program administrator.

Between February 1, 2014 and January 31, 2015 you and your spouse (if covered) may appeal the total Health Reimbursement Arrangement (HRA) incentive funds applied if the HRA dollars are less than you believe should have been awarded to you or your Spouse. Keep proof that you completed the requirements.

For example, keep proof of your office visit to a Physician for the biometric screening (if applicable) and copy of the completed 2014 Physician Screening Form (if applicable). Keep a copy of your completed screening consent form containing results as proof of your onsite screening participation upon completion at a SHBP sponsored event or other Providers identified by SHBP in published materials. When you complete the online Well-Being Assessment™® through www.BeWellSHBP.comSHBP.com, print a copy of the report. When you complete activities through the coaching or online pathway, print screen the rewards balance page. Depending on which 2014 Well-Being Activity you will need to indicate this on the 2014 HRA Incentive Appeal Form.

2014 HRA Incentive Appeal Forms can be found at www.BeWellSHBP.comshbp.com/appeals/. Please submit the proper form along with the required evidence of completion (which may include a copy of your screening results from a Physician or SHBP sponsored screening (if applicable), a Well-Being Assessment completion report, and/or a Well-Being Connect reward center screen capture that displays date of completion. Complete Appeal Forms with attached evidence of completion will be processed within 30 business days of receipt. You will be notified within 30 business days if your appeal is granted or denied. Your Health Reimbursement Arrangement Reward Center Balance on the Healthways Well-Being Connect portal will be updated, if needed. You will be notified in writing if your appeal is approved or denied. If your initial appeal is denied, you will be able to appeal this decision to Healthways by submitting a level two appeal. This form may also be found at www.BeWellshbp.com/appeals. Please note the 2014 action-based incentives will be earned as the action is completed and deposited in your BCBSGa HRA account monthly. If you think you might be unable to complete the 2014 Well-Being Activities, you might qualify to meet the Well-Being requirements by different means. Contact Healthways at: 888-616-6411 and we will work with you (and, if you wish, with your Doctor) to find a Well-Being program with the same reward that is right for you in light of your health status.

2013 Incentives and Wellness Requirements (does not apply to the MA PPO options)

Members and covered spouses who met the 2013 Wellness Requirements will receive the $240 for their HRA in January 2014. This is in addition to the $480 HRA dollars each Member and spouse can earn in 2014. Note: These HRA dollars may be used as long as you are enrolled in a 2014 SHBP HRA Plan option.

Tobacco Cessation

The Tobacco Cessation Telephonic Coaching program is available to Covered Persons age 18 and over to assist them to become tobacco free. Prescription and Over-The-Counter (OTC) tobacco cessation therapies (including Nicotine Replacement Therapy (NRT)) are available for one cycle of OTC or prescription medication as defined below (also defined as one cessation attempt) per plan year. A Covered Person participating in the program must meet the following requirements: 1) Well-Being Coach confirms Member's program eligibility and Member's program enrollment; 2) Member selects a "quit date"; 3) Member obtains a prescription for OTC or Prescribed NRT from their Physician; 4) Member calls and notifies the Well-Being Coach of receipt of the prescription and the medication prescribed; and 5) Member remains actively engaged with their Well-Being Coach for the duration of the Tobacco Cessation Telephonic Coaching Program.

NOTE: Selected tobacco cessation medications will be covered as described in the Outpatient Prescription Drug Rider: 1) a one-time cycle of OTC tobacco cessation medications is available through Retail Network Pharmacy for 8-weeks therapy at no cost to the Member. A 31- day supply will be dispensed for the OTC medication. 1) 1 fill and 1 refill and a prescription is required for coverage. 2) A one-time cycle of Prescription tobacco cessation medications is available through Retail Network Pharmacy for 12- weeks of therapy. The applicable pharmacy Coinsurance will apply. A 31- day supply will be dispensed for the Prescription medications; 1 fill and 2 refills.

You and your covered Dependents 18 years of age or older are allowed to enroll in the coaching program as many times as you like or feel you need. For the medication coverage portion of this program, the SHBP will pay for one cycle of Over The-Counter (OTC) tobacco cessation medication or one cycle of Prescription tobacco cessation medication. If additional cycles of tobacco cessation medications over the allowed one medication attempt covered by the SHBP within the plan year is required please note this will be covered at your own expense.

Tobacco Cessation Telephonic Well-Being Coaching

Resources for quitting tobacco that are available to eligible Members:

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

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

Tobacco Surcharge

Tobacco surcharges are included in all SHBP Options other than Medicare Advantage Options. These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Telephonic Coaching Program. Please go to www.dch.georgia.gov/shbp-publications-forms to access the tobacco surcharge removal policies and forms.

These policies allow you to have the tobacco surcharge removed by completing the surcharge removal requirements through your wellness vendor Healthways.

If you and your enrolled Dependents complete the telephonic tobacco cessation Well-Being coaching program, you will be able to avoid the surcharge for the entire year. This means that any surcharge paid in 2014 will be refunded after the completion of the Well-Being program, the tobacco surcharge removal requirements must all be completed in 2014.

If you think you might be unable to complete the tobacco cessation wellness coaching program, you might qualify for an opportunity to avoid the tobacco surcharge by different means. Contact Healthways at 888-

616-6411 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Tobacco Cessation Therapy Appeals

To file a request for review of denial for prescription and Over the Counter (OTC) tobacco cessation therapies including Nicotine Replacement Therapy (NRT), please complete all applicable sections on the appeal form including any additional facts or materials that are pertinent to the case within 90 days of the denial. The Tobacco Cessation Therapy Appeals form is available at: www.bewellshbp.com/appeals/. Generally a decision is reached within 30 business days of receipt unless additional information is needed.

Definitions

QuitNet® - is Healthways, Inc. tobacco cessation program.

QuitNet.com – is Healthways tobacco cessation website.

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

Outpatient Prescription Drug Rider

Introduction

Outpatient Prescription Drug Rider

This Rider to the Summary Plan Description (SPD) provides Benefits for outpatient Prescription Drug Products.

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

Because this Rider is part of a legal document, we want to give you information about this document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 3: **Glossary of Defined Terms**.

When we use the words "we," "us" and "our" in this document, we are referring to Department of Community Health (DCH), State Health Benefit Plan (SHBP) Division. When we use the words "you" and "your," we are referring to people who are Covered Persons as the term is defined in the SPD Section 3: **Glossary of Defined Terms**.

Prescription Drug Product Benefits will be coordinated with those of any other health coverage plan as described under the "Coordination of Benefits (COB)" section.

Benefits for Outpatient Prescription Drug Products

Express Scripts administers your Prescription Benefit.

This Rider will cover a detailed description about your Prescription Drug plan benefit supply limits; Prior Authorizations (PA); maintenance medications; covered medications; non-covered medications; definitions of Brand-name medications and Generic medications; and the Step Therapy program.

Benefits are available for outpatient Prescription Drug Products on the Express Scripts Prescription Drug list, which meet the definition of a covered health service and are dispensed at a licensed pharmacy. Coinsurance or other payments you are responsible for will vary depending on the outpatient Prescription Drug Product's placement within the three **(3)** tiers of the Express Scripts Prescription Drug List.

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

Coverage Policies and Guidelines

Your Express Scripts pharmacy benefit provides coverage for a comprehensive selection of Prescription medications. The most commonly prescribed medications for certain conditions are named or described in the 2014 Express Scripts National Preferred Formulary (Preferred Drug List/PDL). All Covered Outpatient Prescription Drug Products on the PDL are FDA-approved Prescription Drug Products.

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

Your HRA Plan will have Prescription medications placed in tiers.

Prescription medications are categorized within three (3) tiers. Each tier is assigned a percentage with a minimum and a maximum amount, both of which are determined by your health plan. When you fill a prescription, you pay the Coinsurance based on the cost of your prescription.

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

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

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

Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay Coinsurance and other payments, as set forth on the most current ESI Prescription Drug list. Please consult the Express Scripts National Preferred Drug List or access it through the Internet at: www.Express-Scripts.com/GeorgiaSHBP, or call the Express Scripts Member services number on your SHBP ID card for the most up-to-date tier status.

Tier status and Coinsurance will not be overridden or changed.

Preventive Care Medications

Preventive Care Medications and over-the-counter (OTC) medications are covered as described in the Preventive Care definition in Glossary of Terms. In order for these drugs to be covered, you must obtain a prescription from your Doctor and meet the age/gender requirements.

As part of the ***Patient Protection and Affordable Care Act*** (Health Care Reform), certain contraceptive Prescription Drug Products are covered as Preventive Care Medications at no charge to the Member.

Tobacco Cessation Medications

The Tobacco Cessation Telephonic Coaching program is available to Covered Persons age 18 and older to assist them to become tobacco-free. Prescription and OTC tobacco cessation therapies (including Nicotine Replacement Therapy (NRT)) are available for one cycle of OTC or Prescription medication as defined below (also defined as one cessation attempt) per plan year. A Covered Person participating in the program must meet the following requirements:

1) Well-Being Coach confirms Member's program eligibility and Member's program enrollment;
2) Member selects a "quit date";
3) Member obtains a prescription for an OTC or prescribed NRT from his/her Physician;
4) Member calls and notifies the Well-Being Coach of receipt of the prescription and which medication was prescribed; and
5) Member remains actively engaged with his/her Wellness Coach for the duration of the Tobacco Cessation Telephonic Coaching Program.

NOTE: Selected tobacco cessation medications will be covered as follows:

1) A one-time cycle of OTC tobacco cessation medications is available through a Retail Network Pharmacy for 8 weeks of therapy at no cost to the Member. Up to a 31-day supply will be dispensed for the OTC medication, with 1 additional refill. A prescription is required for coverage.

2) A one-time cycle of select prescription tobacco cessation medications is available through a retail Network Pharmacy for twelve (12) weeks of therapy. The applicable pharmacy Coinsurance will apply. Up to a thirty-one (31)-day supply will be dispensed for the Prescription medications, with 2 additional refills.

You and your covered Dependents 18 years of age or older are allowed to enroll in the coaching program as many times as you would like (or feel you need). For the medication coverage portion of this program, the SHBP will pay for one cycle of OTC tobacco cessation medication or one cycle of select Prescription tobacco cessation medication per plan year. If, within the plan year, additional cycles of tobacco cessation medications beyond the one covered medication attempt are required, please note that these must be purchased at your own expense. Please call: 888-616-6411 to enroll in the Tobacco Cessation Program..

Identification Card (SHBP ID card) – Network Pharmacy

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

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

If you wish to seek reimbursement, you may obtain a Prescription Drug claim form by calling the Express Scripts Member Services number on your SHBP ID card, or log into www.Express-Scripts.com/GeorgiaSHBP. You may print a copy of the Prescription Drug claim form from this website. Along with the Prescription Drug claim form, you will need a receipt (from the pharmacy) for your prescription.

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

When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when purchasing the Prescription Drug Product. The amount you are reimbursed will be based on the approved Prescription Drug Cost, less the required Coinsurance. All claims submitted in this manner are still subject to all coverage rules in place at the time the medication was dispensed, including but not limited to Notification and Step Therapy.

Accredo, an Express Scripts Specialty Pharmacy

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether the drugs are administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. Drugs which have been identified as Specialty Prescription Drugs for your benefit plan are listed on the Express Scripts website: www.Express-Scripts.com/GeorgiaSHBP. Your prescriptions must be filled through Accredo's home delivery program if you have a prescription for one of these products. **If you use any pharmacy other than Accredo after the first fill, or in some limited cases 2 fills, you'll be subject *to the entire cost.* Contact Express Scripts at the number on the back of your SHBP ID card for more detail.**

Please see Section 3: Glossary of Defined Terms for definitions of Specialty Prescription Drug Product and Designated Pharmacy. Refer to the heading *What's Covered—Prescription Drug Benefits* within this Rider for details on Specialty Prescription Drug Products.

Limitation on Selection of Pharmacies

If Express Scripts determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, Express Scripts may require you to select a single Network Pharmacy that will provide and coordinate all

future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, Express Scripts will select a single Network Pharmacy for you.

Member Rights and Responsibilities

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

Express Scripts Member Services:

Written Appeals and inquiries related to the Prescription Drug program should be directed to:

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

Express Scripts Disclaimer

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

What's Covered -- Prescription Drug Benefits

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

- Designated as covered at the time the prescription is dispensed when obtained from a Network Pharmacy (Retail, Home Delivery or Specialty Designated Pharmacy), or when a paper claim is filed and the prescription was designated as covered at the time it was dispensed.

- Refer to Exclusions in your Summary Plan Description Section 2: What's Not Covered -- Exclusions and as listed in Section 2 of this Rider

Benefits for Outpatient Prescription Drug Products

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

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

You can obtain information about participating Retail Network Pharmacies by calling the toll-free number on the back of your SHBP ID card, or log into www.Express-Scripts.com/GeorgiaSHBP. Active HRA Wellness Employees that enroll in the Disease Management Program for Diabetes, Coronary Artery Disease (CAD) and Asthma may qualify for an Rx Coinsurance waiver. You must contact Care Coordination at BCBS Georgia to enroll.

When a Brand-name Drug Becomes Available as a Generic

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

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Coinsurance payment, you may receive a Prescription Drug Product up to the stated supply limit.

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

You may determine whether a Prescription drug has been assigned a supply limit for dispensing through www.Express-Scripts.com/GeorgiaSHBP, or by calling the Express Scripts Member Services number on your SHBP ID card.

Network Pharmacy Notification, Prior Authorization, or Coverage Review Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your Pharmacist or you must notify Express Scripts. The reason for notifying Express Scripts is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, meets the definition of a Covered Health Service and is not an Experimental, Investigational or Unproven Service.

When Prescription Drug Products are dispensed at a Network Pharmacy and require Notification (also known as Prior Authorization), the prescribing Provider, the Pharmacist or you are responsible for notifying Express Scripts. If a prescription is filled by an Out-of-Network Pharmacy and Notification is required by the plan for that drug then you or your Physician are responsible for making sure you notify Express Scripts for approval.

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

If you wish to seek reimbursement, you may obtain a Prescription Drug claim form from Express Scripts by calling the Express Scripts Member Services number on your SHBP ID card, or log into www.Express-Scripts.com/GeorgiaSHBP. You may print a copy of the Prescription Drug claim form from this website. Along with the Prescription Drug claim form, you will need a receipt for your prescription and an explanation of Benefits (EOB) from your primary carrier (if applicable).

Please note: Notification approval will be required before the claim will be considered for reimbursement. Notification in effect at the time the medication was dispensed will be applied to the review. If Express Scripts is notified within 12 months after you pay the Full Retail Cost and the Notification is denied, you will not be reimbursed.

Step Therapy Program Requirements

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

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

Clinical Appeal Process

If a Notification or quantity limitation request is denied by Express Scripts, you or your Physician may initiate the clinical Appeals process.

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

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

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

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

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

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

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

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

The external review program is not available if the adverse benefit determination is based on explicit benefit Exclusions or defined benefit limits. You can submit your request in any of the following three ways:

1. Submit electronically to this e-mail address: DisputedClaim@opm.gov

2. Fax to: 202-606-0036

3. Mail to: Disputed Claims
Office of Personnel Management
P.O. Box 791
Washington, D.C. 20044

Contact Express Scripts at the toll-free number on your SHBP ID card for more information.

How to Fill Your Prescription At An Out-of-Network Pharmacy or At a Network Pharmacy When You Do Not Present Your SHBP ID card

When you use an Out-of-Network Pharmacy, or if you do not show your SHBP ID card or provide verifiable information at a Network Pharmacy, you must pay the Full Retail Cost (Usual and Customary Charge) for your prescription and then submit a claim form to Express Scripts for reimbursement of covered drug costs. Your claim must be submitted within 12 months from the date of service in order to be eligible for consideration of reimbursement. Assignment of Benefits (AOB) is not available.

If you wish to seek reimbursement, you may obtain a Prescription Drug claim form from Express Scripts by calling the Member services number on SHBP ID card or log into www.Express-Scripts.com/GeorgiaSHBP. You may print a copy of the claim form from this website. Along with the Prescription Drug claim form, you will need a receipt for your prescription and an explanation of Benefits from your primary carrier (if applicable).

The Prescription Drug claim form must be filled out in its entirety. Any missing information may cause a delay in processing your reimbursement. Required information includes the pharmacy seven-digit NCPDP number (this number should be identified on your pharmacy receipt), the National Drug Code (NDC) number for your prescription (this can be obtained from your pharmacy), the prescription number, the name of the pharmacy, the Physician's name, the Member ID number, and the patient's name and date of birth. A pharmacy receipt and an EOB from your primary carrier (if applicable) will also be required with the claim form. You will be reimbursed the approved Prescription Drug Cost less the applicable Coinsurance. Also, you are subject to Benefit plan rules (including but not limited to Notification and Step Therapy) which were in effect at the time the medication was dispensed as well as balance billing if the charged amount exceeds the network cost of your prescription(s). If the Notification is not approved or Step Therapy requirements were not

met, then you will not be able to be reimbursed for your claim.

Coordination of Benefits (COB)

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

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

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

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

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

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

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

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

To request a secondary payment from Express Scripts after the time of purchase, you can send a Prescription Drug claim form and attach a copy of the EOB from the primary plan and the pharmacy receipt. You can obtain a copy of the Prescription Drug claim form by calling the Express

Scripts Member services number on your SHBP ID card, or log into: www.ExpressScripts.com/GeorgiaSHBP.

When the SHBP is the secondary plan, Benefits are coordinated to pay only the difference between the amount paid by the primary plan and the allowable amount payable by the SHBP, less any applicable Coinsurance.

Note: The amount paid as secondary payor will not exceed the allowable amount payable by the SHBP, less any applicable Coinsurance. Please call the Express Scripts Member services number on your SHBP ID card for more details.

If you have coverage under two SHBP contracts (cross-coverage or dual coverage), Prescription Drug Benefits provided by the SHBP will not be coordinated. Coinsurance will be required for each filled prescription. If you have coverage under a Medicare Advantage plan, Benefits provided by the SHBP pharmacy Benefits will not be coordinated.

Payment Information

Coinsurance for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount and/or a percentage of the Prescription Drug Cost. Your Coinsurance is determined by the SHBP.

NOTE: Your Coinsurance for a Prescription Drug Product at a Network or Out-of-Network Pharmacy (filed with a Prescription Drug claim form) does not apply to your medical Deductible or Out-of-Pocket Maximum.

Coinsurance payments will not be overridden or changed on an individual basis.

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

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

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

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

See the Coinsurance stated in the Benefit Information table for amounts.

You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications filled in accordance with federal preventative care guidelines. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug plan include those for Preventive Care Medications as defined under Section 3, Glossary of Defined Terms. You may determine whether a drug is a Preventive Care Medication through www.Express-Scripts.com/GeorgiaSHBP or by calling the Express Scripts Member Services telephone number on your SHBP ID card.

Pharmacy Type and Supply Limits

Prescription Drugs from a Participating Retail Network Pharmacy or a Retail Non-Network Pharmacy

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

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

Active Employees that enroll in the Disease Management Program for Diabetes, Coronary Artery Disease (CAD) and Asthma may qualify for an Rx Coinsurance waiver. You must contact Care Coordination at BCBS Georgia to enroll.

Please note: In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Pharmacy.

Your Coinsurance is determined by the tier to which the Express Scripts Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the PDL are assigned to Tier 1, Tier 2 or Tier 3. Please consult your PDL or access www.Express-Scripts.com/GeorgiaSHBP, or call the Express Scripts Member Services number on your SHBP ID card to determine tier status.

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

Tier 1: 15% ($20 min/$50 max)
Tier 2: 25% ($50 min/ $80 max)
Tier 3: 25% ($80 min/$125 max)

Prescription costs do not apply to the Deductible or Out-of-Pocket Maximum.

Coinsurance payments will not be overridden or changed on an individual basis.

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

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

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

You must use Accredo to receive coverage for Specialty Prescription Drug Products. If you do not use Accredo, the Specialty Prescription Drug Product is not eligible for coverage and you will be required to pay the Full Retail Cost for that prescription at the retail pharmacy.

Initially, you may obtain one fill, or in some limited cases 2 fills, of your Specialty Prescription Drug Product from a participating Retail Network Pharmacy. Thereafter, you will be required to use Accredo to continue coverage for your Specialty Prescription Drug Product. For more information, contact Express Scripts at the number listed on the back of your SHBP ID card.

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

Tier 1: 15% ($20 min/$50 max)
Tier 2: 25% ($50 min/ $80 max)
Tier 3: 25% ($80 min/$125 max)

Prescription Drug Products from Express Scripts Home Delivery

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

As written by the Provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

Your Doctor must write your prescription for a 90-day or 3-month supply with refills when appropriate (not a 1-month supply with three refills).

Please note: You will be charged a 90 day Home Delivery Coinsurance regardless of the days' supply actually dispensed.

To fill the prescription, you may:

- Mail your prescription(s) along with the required form in the envelope provided with your Welcome Package.
- Ask your Doctor to call 888-327-9791 for instructions on how to fax the prescription. Your Doctor must have your Member ID number (which is on your SHBP Member ID card) to fax your prescription.
- Order through the Express Scripts website after registering at www.ExpressScripts.com /GeorgiaSHBP.

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

Active Employees that enroll in the Disease Management Program for Diabetes, Coronary Artery Disease (CAD) and Asthma may qualify for an Rx Coinsurance waiver. Members may obtain a 90 day supply of medications they have qualified to obtain under the Rx Coinsurance Waiver program through their retail pharmacy or through Express Scripts Home Delivery if that prescription is written for a 90 day supply. Members should contact BCBSGa on the back of your SHBP ID card for more information regarding the Rx Coinsurance Waiver program.

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

Tier 1: 2 ½ x Coinsurance for up to a 90-day supply ($50 min, $125 max)

Tier 2: 2 ½ x Coinsurance for up to a 90-day supply ($125 min, $200 max)

Tier 3: 2 ½ x Coinsurance for up to a 90-day supply ($200 min, $312.50 max)

When you obtain a maintenance supply of drugs from the Express Scripts Pharmacy Home Delivery Service, your cost sharing may be lower. Express Scripts offers two ways to obtain up to a 90-day supply of maintenance drugs.

1. Some participating retail pharmacies in our Network allow you to get up to a 90-day supply of maintenance drugs at the home delivery Coinsurance rates. These are called 90 day retail network pharmacies. To determine which participating retail pharmacies pass through the discounted Coinsurance rates for a 90 day supply, visit www.ExpressScripts.com/GeorgiaSHBP and click "Locate a pharmacy." Any participating 90-day retail pharmacy will have the following statement after the address: "Dispenses a maintenance supply: YES". You can also locate participating retail pharmacies on the Express Scripts mobile app or by calling Express Scripts at the number on the back of your SHBP ID Card.
2. You can use the Express Scripts Pharmacy Home Delivery Service. Home Delivery from an Out-of-Network Pharmacy is NOT covered.

What's Not Covered -- Exclusions

Exclusions from coverage listed in other areas of the SPD may also apply to this Rider. In addition, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) that exceeds the supply limit.

2. Drugs that are prescribed dispensed or intended for use while you are an Inpatient in a Hospital, Skilled Nursing Facility or Alternate Facility.

3. Experimental, Investigational or Unproven Services and medications; medications and/or indications not approved by the Food and Drug Administration (FDA) used for experimental indications and/or dosage regimens determined by Express Scripts to be experimental, investigational or unproven.

4. Prescription Drug Products furnished by the local, state or Federal government. Any Prescription Drug Product to the extent payment or Benefits are provided or available from the local, state or Federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.

5. Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.

6. Any product dispensed for the purpose of appetite suppression and other weight loss products.

7. An injectable Prescription Drug Product (including, but not limited to, immunizations and allergy serum) that, due to its characteristics as determined by Express Scripts, must typically be administered or supervised by a qualified Provider or licensed/certified health professional in an outpatient setting. This Exclusion does not apply to Gardasil, Ceravix and Zostavax vaccines self-administered injectable medications and Specialty medications covered through your Pharmacy Benefit plan.

8. The cost of labor and additional charges for compounding prescriptions, excluding contractual dispensing fees that Pharmacies charge.

9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered. Contact Express Scripts customer service for a list of covered diabetic supplies and inhaler spacers.

10. General vitamins except the following, which require a prescription: prenatal vitamins, vitamins with fluoride and single-entity vitamins.

11. Medications used for cosmetic purposes.

12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.

13. Prescription Drug Products when prescribed to treat infertility.

14. Prescription Drug Products for tobacco cessation (except for OTC and Prescription Drug Products prescribed for participation in the Tobacco Cessation Telephonic Coaching Program administered by Healthways, the wellness vendor. See Wellness section for more details).

15. Compounded drugs that do not contain at least one covered ingredient that requires a prescription.

16. Drugs available over-the-counter that does not require a prescription by federal or state law before being dispensed except for certain preventive OTC drugs – aspirin, fluoride, folic acid and Iron, subject to plan limitations, – that require a prescription for coverage.

17. Any Prescription Drug Product that is therapeutically equivalent to an OTC drug. Prescription Drug Products that comprise components that are available in OTC form or an equivalent.

18. Yohimbine.

19. Mifeprex.

20. Blood or blood plasma products except for hemophilia factors.

21. Growth hormone used for the treatment of short stature in the absence of identified sickness or injury.

22. Specialty Prescription Drugs purchased at a pharmacy that is not a Specialty Designated Pharmacy (except for the first prescription fill or in some limited cases two prescription fills of the Specialty Prescription Drug, which may be purchased from a Retail or Home Delivery Pharmacy).

23. Nutritional supplements, except for those specifically identified as included under the plan. Contact ESI's customer service for a list of covered supplements.

Frequently Asked Questions

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

What is a Prescription Drug List (PDL)?

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

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

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

Understanding Tiers

Prescription medications are categorized within three tiers. Each tier is assigned a Coinsurance, the amount you pay when you fill a prescription, which is determined by your health plan. Consult your Benefit plan documents to find out the specific Coinsurance payments that are part of your plan. You and your Doctor decide which medication is appropriate for you.

Tier 1: Your Lowest-Cost Option

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

Tier 2: Your Midrange-Cost Option

Tier 2 medications are your middle Coinsurance option.

Tier 3: Your Highest-Cost Option

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

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

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

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

The Formulary Review Process:

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

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

How often will Prescription medications change tiers?

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

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

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

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

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

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

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

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

What is a maintenance medication program?

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

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

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

Which maintenance medications are included in the maintenance medication program?

Maintenance medications include but are not limited to:

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

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

What are the supply limits (SL) programs?

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

How do the SL programs work?

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

You will have the following options:

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

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

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

How does the program work?

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

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

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

Please call Express Scripts Member Services number on your SHBP ID card to determine whether a medication is covered as a self-administered injectable under your Pharmacy or Medical Benefits.

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

If you are going to run out of medication while you are on vacation, you may receive an early 3-month supply up to two times per year for your maintenance medications. For a non-maintenance medication, you can get 2 overrides for an early fill during the year. You will be responsible for the Coinsurance associated with that supply. There are some limitations with controlled or temperature-sensitive medications. For more information, call the Express Scripts Member Services number on your SHBP ID card.

If you would like to obtain a supply of medication prior to leaving for your vacation, you will need to inform your local Network Pharmacist. Your Pharmacist should know how to process your vacation request, however if not please have your Pharmacist contact the Express Scripts Pharmacy help desk at 1-800-922-1557.

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

How do I access updated information about my Pharmacy Benefit?

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

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

What if I still have questions?

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

PHARMACY GLOSSARY AND DEFINITIONS

This section defines the terms used throughout this Rider.

Other defined terms used throughout this Rider can be found in Section 3: Glossary of Defined Terms of your Summary Plan Description. This section is not intended to describe Benefits.

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

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

Coverage Review: See Prior Authorization

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

Coinsurance: The portion of the total cost of the claim that must be paid by the Member.

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

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

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

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

Network Pharmacy: A pharmacy that has:

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

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

New Prescription Drug Product: A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following date: December 31st of the following plan year.

Notification: See Prior Authorization

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

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

- Inhalers (with spacers)
- Insulin

The following diabetic supplies:

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

Preventive Care Medications: The medications that are obtained at a Network Pharmacy with a

Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible as required by applicable law under any of the following:

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

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

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

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

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

Step Therapy: means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products, you are required to use (a) different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

End of Outpatient Prescription Drug Rider

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology.. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card; or refer to the Claims Administrator's website at: www.bcbsga.com/shbp.

Special Enrollment Notice

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

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

The Covered Person or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request Special Enrollment or obtain more information, call the Customer Service telephone number on the back of your Identification Card, or contact your Benefit Coordinator/Payroll Location.

Women's Health and Cancer Rights Act of 1998

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

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance
- Prostheses and mastectomy bras
- Treatment of physical complications of mastectomy, including lymphedema

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

For more detailed information on the mastectomy-related Benefits available under the Plan, you can contact the Member Services unit for your coverage option. Telephone numbers are on the inside front cover of the Decision Guide.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

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

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection and Affordable Care Act (—PPACA

Patient Protection Notices

The Medical Claims Administrator generally allows the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in the Medical Claims Administrator's network and who is available to accept you or your family Members. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact the Medical Claims Administrator at the toll-free number on the back of your ID card.

For children, you may designate a pediatrician as the Primary Care Provider.

You do not need Prior Authorization from the Medical Claims Administrator or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Medical Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Medical Claims Administrator at the toll-free number on the back of your ID card.

Health Insurance Portability and Accountability Act Notice of Information Privacy Practices

Georgia Department of Community Health
State Health Benefit Plan Notice of Information Privacy Practices
Revised October 16, 2013

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

The Georgia Department of Community Health (DCH) and the State Health Benefit Plan Are Committed to Your Privacy. The DCH is the Plan Sponsor and administers the health plan through the State Health Benefit Plan (the Plan). The DCH understands that your information is personal and private. Certain DCH employees and companies hired by DCH to help administer the Plan (Plan Representatives) use and share your personal and private information in order to administer the Plan. This information is called "Protected Health Information" or "PHI." This notice tells how your PHI is used and shared by the DCH and Plan Representatives. The DCH follows the information privacy rules of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA").

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

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

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

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

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

Plan Representatives Regularly Use and Share your PHI in Order Administer the Plan. Plan Representatives use and share your PHI in order to administer the Plan. For example, Plan Representatives may verify your eligibility in order to make payment to your health care Providers for services rendered. Certain Plan Representatives may work for contracted companies assisting the administration of the Plan. By law, these Plan Representative companies also must protect your PHI. They also must sign "Business Associate" agreements with the Plan to ensure compliance. Additionally, Plan Representative Companies may need to share PHI data in order to administer the Plan.

Below are some examples of Plan Representative Companies and PHI data sharing. These include, but are not limited to the following:

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

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

Actuarial, Health Care and /or Benefit Consultant Companies: Plan Representatives may have access to PHI in order to conduct financial projections, premium and reserve calculations and financial impact studies on legislative policy changes affecting the Plan. However, they are prohibited by law from using any PHI that includes genetic information for these purposes.

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

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

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

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

Plan Representatives May Make Special Uses or Disclosures Permitted by Law. HIPAA has a list of special situations or uses when the Plan may use or share your PHI without your authorization as permitted by law. The Plan must track the special use or disclosure. Below are some examples of special uses or disclosures for PHI data sharing permitted by law. These include, but are not limited to the following:

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

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

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

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

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

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

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

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

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

Right to Ask for a Restriction of Uses and Disclosures, or for Special Communications: You have the right to ask for added restrictions on uses and disclosures. You also may ask the Plan to communicate with you at a different address in order to protect your safety.

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

Address to File HIPAA Complaints:

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

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

For more information about this notice, contact:

Georgia Department of Community Health State Health Benefit Plan
P.O. Box 1990 Atlanta, GA 30301, 1-800-610-1863

Mental Health Parity and Addiction Equity Act Opt-Out Notice

Election to be Exempt from Certain Requirements of HIPAA September 6, 2013

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

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must comply with a number of requirements. Under HIPAA, state health plans that are "self-funded" may "opt out" of some of these requirements by making a yearly election to be exempt. Your plan option is self-funded because the Department of Community Health pays all claims directly instead of buying a health insurance policy.

Temporary rules implementing the Mental Health Parity and Addiction Equity Act apply January 1, 2014 unless the Department of Community Health again elects to be exempted from this law's requirements. The temporary rules generated over 4,000 comments, and no final rules addressing these comments have been issued. The Department of Community Health has determined to exempt your State Health Benefit Plan ("SHBP") option from the Mental Health Parity and Addiction Equity Act, and the temporary rules' requirements, for the 2014 calendar year.

Parity in the application of certain limits to mental health Benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical Benefits and mental health or substance use disorder Benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder Benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical Benefits covered by the plan.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2014 and ending December 31, 2014. The election may be renewed for subsequent plan years.

HIPAA also requires the SHBP to provide covered employees and Dependents with a "certificate of creditable coverage" when they cease to be covered under the SHBP. There is no exemption from this requirement. The certificate provides evidence that you were covered under the SHBP, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition Exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Centers for Medicare & Medicaid Services Medicare Part D Creditable Coverage Notice

Important Notice from the Department of Community Health About Your 2014 Prescription Drug Coverage under the State Health Benefit Plan HRA Options and Medicare For Plan Year: January 1 – December 31, 2014

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

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

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

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Department of Community Health has determined that the Prescription Drug coverage offered under SHBP are, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and are, therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

Contact the SHBP Call Center at 1 800-610-1863. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHPB changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage…

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

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

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

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