Blue Cross and Blue Shield Georgia (BCBSGa)

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

FOR

SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health

HRA OPTIONS: GOLD, SILVER and BRONZE
Administered By

Effective Date: January 1, 2018

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 the BCBSGa Member Services at the number on the back of your Member Identification Card (ID card).
INTRODUCTION

This Summary Plan Description (“SPD”) gives you a description of your Benefits while you are enrolled under the State Health Benefit Plan (the “Plan”). The SHBP is a Calendar Year Plan. The Benefit Period starts on January 1, 2018 and ends on December 31, 2018. The Department of Community Health (DCH) reserves the right to act as sole interpreter of all the terms and conditions of the Plan, except where expressly delegated to the claims administrators. You should read this SPD carefully and keep it handy for reference. A thorough understanding of your coverage will allow you to maximize your Benefits. If you have any questions about the Benefits shown in this SPD, please call the BCBSGa Member Service number on the back of your Member ID Card, provided by the medical claims administrator.

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

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

**Note:** Please refer to the Eligibility and Enrollment Provisions document that contains the Plan’s eligibility requirements at [www.shbp.georgia.gov](http://www.shbp.georgia.gov), posted separately as part of the SPD.

Many words used in this SPD have special meanings (e.g. Covered Services and Medical Necessity). These words are capitalized and are defined in the “Definitions” Section. See these definitions for the best understanding of what is being stated.

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

The Benefits described in this SPD or any rider or amendments attached hereto are funded by the Plan Sponsor who is responsible for a portion of their payment. Blue Cross and Blue Shield of Georgia (BCBSGa) provides administrative medical claims payment services only, and CVS Caremark only provides administrative pharmacy claims payment services. Sharecare 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 BCBSGa Member Services number on your Member ID Card, and a representative will be able to help you. TTY/TDD services also are available.
<table>
<thead>
<tr>
<th>Medical Claims Administrator- Blue Cross and Blue Shield of Georgia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Services</strong></td>
</tr>
<tr>
<td>Hours: 8:00 a.m. – 8:00 p.m. ET</td>
</tr>
<tr>
<td>Monday – Friday</td>
</tr>
<tr>
<td>Fraud Hotline</td>
</tr>
<tr>
<td>800-831-8998</td>
</tr>
<tr>
<td>24 / 7 Nurse Line</td>
</tr>
<tr>
<td>866-787-6361</td>
</tr>
<tr>
<td>Personal Health Coach</td>
</tr>
<tr>
<td>Hours: 8:00 a.m. – 6:00 p.m. ET</td>
</tr>
<tr>
<td>Future Moms</td>
</tr>
<tr>
<td>866-901-0746</td>
</tr>
<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>855-679-5722</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wellness Program Administrator- Sharecare (formerly known as Healthways)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Services</strong></td>
</tr>
<tr>
<td>Hours: 8:00 a.m. – 8:00 p.m. ET</td>
</tr>
<tr>
<td>Monday – Friday</td>
</tr>
<tr>
<td>Corporate Compliance</td>
</tr>
<tr>
<td>844-401-0005</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Benefits Administrator- CVS Caremark</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Services</strong></td>
</tr>
<tr>
<td>Hours: 24 hours a day / 7 days a week</td>
</tr>
<tr>
<td>844-345-3241</td>
</tr>
<tr>
<td>TTY Line</td>
</tr>
<tr>
<td>800-231-4403</td>
</tr>
<tr>
<td>Fraud Hotline</td>
</tr>
<tr>
<td>877-CVS-2040</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SHBP Member Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hours:</strong> 8:30 a.m. – 5:00 p.m. ET</td>
</tr>
<tr>
<td>Monday – Friday</td>
</tr>
<tr>
<td>Saturday 8:00 a.m. to 5:00 p.m. ET</td>
</tr>
<tr>
<td>800-610-1863</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centers for Medicare &amp; Medicaid (CMS)</strong></td>
</tr>
<tr>
<td>24 hours a day / 7 days a week</td>
</tr>
<tr>
<td>800-633-4227</td>
</tr>
<tr>
<td>TTY 877-486-2048</td>
</tr>
</tbody>
</table>

[www.bcbsga.com/shbp](http://www.bcbsga.com/shbp)
[www.BeWellSHBP.com](http://www.BeWellSHBP.com)
[info.caremark.com/shbp](http://info.caremark.com/shbp)
[www.mySHBPga.adp.com](http://www.mySHBPga.adp.com)
[www.medicare.gov](http://www.medicare.gov)
# TABLE OF CONTENTS

**Introduction** .................................................................................................................. 2
**State Health Benefits Plan (SHBP) Contact / Resources Information** .......................... 3
**Table of Contents** .......................................................................................................... 4
**Schedule of Benefits** ..................................................................................................... 5
**How the SHBP HRA Plan Works** .................................................................................. 19

## Medical Claims Administrator

- **How Your Medical Plan Works** ................................................................................... 21
- **Getting Approval for Benefits** .................................................................................... 24
- **Voluntary Incentive Programs** ................................................................................... 30
- **What is Covered** .......................................................................................................... 32
- **What is Not Covered** .................................................................................................... 48
- **Medical Claims Payment** ............................................................................................ 53
- **Coordination of Benefits When Members Are Insured Under More Than One Plan** .... 59
- **Subrogation and Reimbursement** ............................................................................... 62
- **Member Rights and Responsibilities** .......................................................................... 63
- **Your Right to Appeal** .................................................................................................. 64
- **General Provisions** ...................................................................................................... 67
- **BCBSGa Medical Definitions** .................................................................................... 70

End of Medical Claims Administrator Section

## Wellness Program Administrator

- **Well-Being Program – Be Well SHBP** ....................................................................... 78
- **2018 Well-Being Program Features** ......................................................................... 80
- **Sharecare Well-Being Services** ............................................................................... 81
- **Tobacco Cessation** ...................................................................................................... 84
- **2018 Well-Being Incentive Credits Appeal Process** .................................................. 85
- **Sharecare Definitions** ................................................................................................. 86

End of the Wellness Program Administrator Section

## Pharmacy Benefits Administrator

- **Outpatient Prescription Drug Rider** .......................................................................... 87
- **What is Covered- Prescription Drug Benefits** ............................................................. 90
- **Pharmacy Type and Supply Limits** ........................................................................... 94
- **What is Not Covered- Prescription Drug Exclusions** ............................................... 96
- **Frequently Asked Questions- Prescription Drug** ....................................................... 97
- **Prescription Drug Glossary and Definitions** ............................................................... 102

End of Pharmacy Benefits Administrator Section

## Federal Patient Protection and Affordable Care Act Notices

- ................................................................................................................................. 104
SCHEDULE OF BENEFITS

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

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

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

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

Note: Pharmacy Benefits are administered separately by the Pharmacy Benefits Administrator, CVS Caremark and are the same in all Plan Options- Gold, Silver, and Bronze Health Reimbursement Arrangement (HRA) Plans. See the table “Prescription Drug Pharmacy Benefits” in this Section & the “Outpatient Prescription Drug Rider” Section in this SPD.

<table>
<thead>
<tr>
<th>SHBP Base HRA Credits Contributions to Your HRA</th>
<th>Gold HRA Plan</th>
<th>Silver HRA Plan</th>
<th>Bronze HRA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>400</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>You + Spouse</td>
<td>600</td>
<td>300</td>
<td>150</td>
</tr>
<tr>
<td>You + Children</td>
<td>600</td>
<td>300</td>
<td>150</td>
</tr>
<tr>
<td>You + Family</td>
<td>800</td>
<td>400</td>
<td>200</td>
</tr>
</tbody>
</table>

NOTE: HRA well-being incentive credits will reduce your Deductible and Out-of-Pocket Maximum. Prescription costs do apply to your HRA well-being incentive credits, when credits are available.

If you do not use all of the HRA well-being incentive credits in your HRA, the credits roll over from year to year, as long as you remain continuously enrolled in a SHBP plan option (excluding the TRICARE Supplement). See “Well-Being Incentive Programs” in the Sharecare Section of the SPD on how to earn more HRA well-being incentive credits.
<table>
<thead>
<tr>
<th>Deductible</th>
<th>SHBP Coverage Tier</th>
<th>Gold HRA Plan</th>
<th>Silver HRA Plan</th>
<th>Bronze HRA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>You</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>You + Spouse</td>
<td>$2,250</td>
<td>$4,500</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>You + Children</td>
<td>$2,250</td>
<td>$4,500</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>You + Family</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

The Deductible applies to all Covered Services unless otherwise indicated.

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

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

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

Member Prescription costs do not apply to the Deductible.

**Note:** You + Spouse, You + Child(ren) or You + Family Deductibles are aggregate Deductibles. This means any combination of amounts paid by these tiers for Covered Services can be used to satisfy the applicable tiered Deductible.

<table>
<thead>
<tr>
<th>Co-insurance</th>
<th>Gold HRA Plan</th>
<th>Silver HRA Plan</th>
<th>Bronze HRA Plan</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Pays (unless otherwise noted)</td>
<td>85%</td>
<td>80%</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td>Member Pays (unless otherwise noted)</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Your Co-insurance for In-Network Providers will be based on the Maximum Allowed Amount for Covered Services.

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

**Note:** Pharmacy benefits are administered separately by the Pharmacy Benefits Administrator and are the same in all Plan Options- Gold, Silver, and Bronze HRA Plans.
<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum</th>
<th>Gold HRA Plan</th>
<th>Silver HRA Plan</th>
<th>Bronze HRA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>SHBP Coverage Tier</strong></td>
<td></td>
<td></td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>You</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>You + Spouse</td>
<td>$6,000</td>
<td>$12,000</td>
<td>$7,500</td>
</tr>
<tr>
<td>You + Children</td>
<td>$6,000</td>
<td>$12,000</td>
<td>$7,500</td>
</tr>
<tr>
<td>You + Family</td>
<td>$8,000</td>
<td>$16,000</td>
<td>$10,000</td>
</tr>
<tr>
<td></td>
<td>$5,000</td>
<td>$10,000</td>
<td>$6,000</td>
</tr>
<tr>
<td></td>
<td>$7,500</td>
<td>$15,000</td>
<td>$9,000</td>
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<tr>
<td></td>
<td>$7,500</td>
<td>$15,000</td>
<td>$9,000</td>
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<td>$20,000</td>
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<td>$6,000</td>
<td>$12,000</td>
<td>$9,000</td>
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<tr>
<td></td>
<td>$9,000</td>
<td>$18,000</td>
<td>$9,000</td>
</tr>
<tr>
<td></td>
<td>$12,000</td>
<td>$24,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

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

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

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

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

HRA credits will reduce the Out-of-Pocket Maximum

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

Proration does not apply to the Out-of-Pocket Maximum.

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

Once the Out-of-Pocket Maximum is satisfied, you will not have to pay any additional Deductibles or Co-insurance for medical and/or pharmacy Covered Services for the rest of the Benefit Period, except for the services listed above.
## Gold, Silver, & Bronze HRA Plans

### Prescription Drug Pharmacy Benefits

#### Co-insurance you must pay

<table>
<thead>
<tr>
<th>31-day supply for a participating Retail Network Pharmacy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 Co-insurance Generic</td>
<td>15% ($20 min/ $50 max) for up to 31-day supply</td>
</tr>
<tr>
<td>Tier 2 Co-insurance (Preferred) Brand</td>
<td>25% ($50 min/ $80 max) for up to 31-day supply</td>
</tr>
<tr>
<td>Tier 3 Co-insurance (Non-Preferred) Brand</td>
<td>25% ($80 min/ $125 max) for up to 31-day supply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>90-day Supply for maintenance drugs from mail order OR at participating 90-Day Retail Network Pharmacies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: 2½ x the monthly Co-insurance</td>
<td>15% ($50 min/ $125 max) for up to a 90-day supply</td>
</tr>
<tr>
<td>Tier 2: 2½ x the monthly Co-insurance</td>
<td>25% ($125 min/ $200 max) for up to a 90-day supply</td>
</tr>
<tr>
<td>Tier 3: 2½ x the monthly Co-insurance</td>
<td>25% ($200 min/ $313 max) for up to a 90-day supply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>90-day Supply for maintenance drugs from a Retail Network Pharmacy which is not part of the 90-Day Retail Network Pharmacies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: 3 x the monthly Co-insurance</td>
<td>15% ($60 min/ $150 max) for up to a 90-day supply</td>
</tr>
<tr>
<td>Tier 2: 3 x the monthly Co-insurance</td>
<td>25% ($150 min/ $240 max) for up to a 90-day supply</td>
</tr>
<tr>
<td>Tier 3: 3 x the monthly Co-insurance</td>
<td>25% ($240 min/ $375 max) for up to a 90-day supply</td>
</tr>
</tbody>
</table>

Prescription drug pharmacy benefits are administered separately by the Pharmacy Benefits Claims Administrator, CVS Caremark and are the same in all three Plan options—Gold, Silver, and Bronze HRA Plans.

Co-insurance for a Prescription Drug Product at Network Pharmacy is a percentage of the allowed amount. Your Co-insurance is based on the applicable drug tier. Co-insurance will not be overridden or changed on an individual basis.

Please see the “Outpatient Prescription Drug Rider” in this SPD.

If a generic product is available and you choose to use the branded product instead, then you will pay the applicable generic co-insurance plus the cost difference between the generic product and its brand product, referred to as Ancillary Charge. This differential will not apply to your Out-of-Pocket Maximum.

**Note:** Prescription costs do not apply to the Deductible but do apply to the Member’s Out-of-Pocket Maximum.
Cost shares you must pay for Covered Services
Please refer to the Section “What is Covered” for additional detail

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Gold Plan In-Network</th>
<th>Silver Plan In-Network</th>
<th>Bronze Plan In-Network</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
</table>

### Allergy Services (Testing and Treatment)
- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)
  - 15% Co-insurance after Deductible
  - 20% Co-insurance after Deductible
  - 25% Co-insurance after Deductible
  - 40% Co-insurance after Deductible

### Ambulance Services (Air, Water and Ground)
- 15% Co-insurance per trip after Deductible
- 20% Co-insurance per trip after Deductible
- 25% Co-insurance per trip after Deductible
- Same as In-Network

Out-of-Network Providers may also bill you for any charges that exceed the Plan’s Maximum Allowed Amount.

**Important Note:** Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see “Getting Approval for Benefits” for details.

### Autism Spectrum Disorder (ASD) Applied Behavior Analysis (ABA)
- 15% Co-insurance not subject to Deductible
- 20% Co-insurance not subject to Deductible
- 25% Co-insurance not subject to Deductible
- Same as In-Network

**Important Note:** Prior Authorization is required and is limited to medically necessary ABA for the treatment of ASD to a maximum benefit of $35,000 per year per approved member (through age 20).

### Cardiac Rehabilitation
- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)
  - 15% Co-insurance after Deductible
  - 20% Co-insurance after Deductible
  - 25% Co-insurance after Deductible
  - 40% Co-insurance after Deductible

- Outpatient Facility Services
  - Cardiac Rehabilitation Benefit Maximum
    - 40 visits per Benefit Period
    - In- and Out-of-Network visits combined

**Note:** The limit for cardiac rehabilitation will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Gold Plan In-Network</th>
<th>Silver Plan In-Network</th>
<th>Bronze Plan In-Network</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chemotherapy / Non-Preventive Infusion &amp; Injection</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>- Outpatient Facility Services</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td><strong>Chiropractic Services / Manipulation Therapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>- Outpatient Facility Services</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>o  Chiropractic Services / Manipulation Therapy Benefit Maximum</td>
<td></td>
<td>20 visits per Benefit Period</td>
<td></td>
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<tr>
<td></td>
<td>In- and Out-of-Network visits combined</td>
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<tr>
<td><strong>Diagnostic Services</strong></td>
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</tr>
<tr>
<td>Advanced Diagnostic Imaging (including MRIs, CAT scans)</td>
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<tr>
<td>Diagnostic Labs (non-preventive) (i.e., reference labs)</td>
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</tr>
<tr>
<td>Diagnostic X-ray (non-preventive)</td>
<td></td>
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</tr>
<tr>
<td>- Inpatient Facility Services</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>- Outpatient Facility Services</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td><strong>Dialysis / Hemodialysis</strong></td>
<td></td>
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</tr>
<tr>
<td>- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>- Outpatient Facility Services</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
</tbody>
</table>
Cost shares you must pay for Covered Services
Please refer to the Section “What is Covered” for additional detail

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Gold Plan In-Network</th>
<th>Silver Plan In-Network</th>
<th>Bronze Plan In-Network</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>Emergency Services</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Emergency Room</td>
<td></td>
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</tr>
<tr>
<td>• Emergency Room Facility Charge</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td>• Emergency Room Doctor Charge</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td>• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td>• Advanced Diagnostic Imaging (including MRIs, CAT scans)</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td>• Non-emergency use of Emergency Room Services</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>Note: Emergency services will be covered whether you receive care from an In-Network or Out-of-Network Provider. Please see the “Emergency Care” section of this document for more information.</td>
<td></td>
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</tr>
</tbody>
</table>

Foot Orthotics
(Covered for certain diagnoses such as diabetes)

| Foot Orthotics Benefit Maximum | 1 pair every 3 years |

Hearing (Non-routine Exam, Test & Fitting) and Hearing Aids

| Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) Non-Routine Hearing Exams, Tests & Fittings | 15% Co-insurance after Deductible | 20% Co-insurance after Deductible | 25% Co-insurance after Deductible | Same as In-Network |
| Hearing Aids                                                                    | 0% Co-insurance No Deductible | 0% Co-insurance No Deductible | 0% Co-insurance No Deductible | Same as In-Network |

| Hearing Aid Benefit Maximum | Limited to: $1,500 every 5 years for adults and $3,000 every 4 years for children (0 up to 19) per hearing impaired ear |
Cost shares you must pay for Covered Services
Please refer to the Section “What is Covered” for additional detail

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Gold Plan In-Network</th>
<th>Silver Plan In-Network</th>
<th>Bronze Plan In-Network</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Care</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Home Care Visits</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>• Home Dialysis</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>• Home Infusion Therapy</td>
<td></td>
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</tr>
<tr>
<td>• Other Home Care Services / Supplies</td>
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</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
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</tr>
<tr>
<td>• Home Care</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>• Respite Hospital Stays</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o <strong>Bereavement Benefit Maximum</strong></td>
<td></td>
<td></td>
<td></td>
<td>8 Visits</td>
</tr>
<tr>
<td><strong>Human Organ and Tissue Transplant (Bone Marrow /Stem Cell) Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precertification and Prior Approval required (except for cornea and kidney)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transportation and Lodging</td>
<td>15% Co-insurance no Deductible</td>
<td>20% Co-insurance no Deductible</td>
<td>25% Co-insurance no Deductible</td>
<td>Not Covered unless *BDCT Facility used.</td>
</tr>
<tr>
<td></td>
<td>Covered, as approved by BCBSGa, up to $10,000 per transplant</td>
<td>Out-of-Network Not Covered</td>
<td>$50 per day for the patient or up to $100 per day for the patient plus one companion</td>
<td></td>
</tr>
<tr>
<td>• Transportation and Lodging Limit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Donor Search</td>
<td>15% Co-insurance no Deductible</td>
<td>20% Co-insurance no Deductible</td>
<td>25% Co-insurance no Deductible</td>
<td>Not Covered unless *BDCT Facility used.</td>
</tr>
<tr>
<td>• Donor Search Limit</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure</td>
<td>Covered, as approved by BCBSGa, up to $30,000 Lifetime Maximum</td>
<td>Out-of-Network Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> <em>BCBSGa has Centers of Excellence (COE) Network selected to provide specific services to Members. Members must use a Blue Distinction Center for Transplants (BDCT) or one of the Center of Medical Excellence (CME) Transplant Network facilities to receive benefits for transplant services. Contact BCBSGa Member Services at the number on the back of your Member ID Card for details.</em></td>
<td></td>
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</tr>
<tr>
<td>Covered Services</td>
<td>Gold Plan In-Network</td>
<td>Silver Plan In-Network</td>
<td>Bronze Plan In-Network</td>
<td>Out-of-Network (All Plans)</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Limited to diagnostic services.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Note:</strong> Treatment of infertility is not covered.</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td><strong>Inpatient Facility Services</strong></td>
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<td></td>
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</tr>
<tr>
<td>Facility Room &amp; Board Charge:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital / Acute Care Facility</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>• Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor Service Charges:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• General Medical Care / Evaluation and Management (E&amp;M)</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>• Surgery &amp; Other Doctor Charges</td>
<td></td>
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<tr>
<td><strong>Note:</strong> For Emergency admissions, you (or your authorized representative) or Doctor must inform BCBSGa within 48 hours of the admission.</td>
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</tr>
<tr>
<td><strong>Maternity and Reproductive Health Services</strong></td>
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</tr>
<tr>
<td>• Maternity Services</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>• Prenatal Office Visit Services</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Physician Office Visits Primary Care Physician (PCP) / Specialty Care Physician (SCP)</td>
<td></td>
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</tr>
<tr>
<td><strong>Note:</strong> Deductible applies to mother and well-newborn charges.</td>
<td></td>
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</tr>
<tr>
<td>• Inpatient Services (Delivery)</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
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<tr>
<td>• Inpatient Facility Services</td>
<td></td>
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<tr>
<td>• Inpatient Doctor Services</td>
<td></td>
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</tr>
<tr>
<td><strong>Note:</strong> Deductible applies to mother and well-newborn charges.</td>
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</tr>
</tbody>
</table>

**Note:** Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged home, Covered Services for the newborn will be treated as a separate admission requiring precertification with Deductible and Co-insurance applied. You must also add the dependent to the Plan. Please refer to the Eligibility and Enrollment Provisions document that contains the Plan’s eligibility requirements, posted separately as part of the SPD, at [www.shbp.georgia.gov](http://www.shbp.georgia.gov).
Cost shares you must pay for Covered Services
Please refer to the Section “What is Covered” for additional detail

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

**Occupational Therapy**

- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) | 15% Co-insurance after Deductible | 20% Co-insurance after Deductible | 25% Co-insurance after Deductible | 40% Co-insurance after Deductible |
- Outpatient Facility Services | 15% Co-insurance after Deductible | 20% Co-insurance after Deductible | 25% Co-insurance after Deductible | 40% Co-insurance after Deductible |
- **Occupational Therapy Benefit Maximum** | 40 visits per Benefit Period In- and Out-Of-Network visits combined |

**Note:** The limit for occupational therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.
Cost shares you must pay for Covered Services
Please refer to the Section “What is Covered” for additional detail

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Gold Plan In-Network</th>
<th>Silver Plan In-Network</th>
<th>Bronze Plan In-Network</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits and Physician Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office Visits and Physician Services Primary Care</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td>Physician (PCP) / Specialty Care Physician (SCP)</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>• Online Visits (LiveHealth Online)</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>not subject to</td>
<td>not subject to</td>
<td>not subject to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>• Retail Health Clinic Visit</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>• Office Surgery</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>• Prescription Drugs Administered in the Office</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Doctor Surgery Charges</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>• Other Doctor Charges (including Anesthesiologist,</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td>Pathologist, Radiologist)</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office Visits and Physician Services Primary Care</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td>Physician (PCP) / Specialty Care Physician (SCP)</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>• Outpatient Facility Services</td>
<td>15% Co-insurance</td>
<td>20% Co-insurance</td>
<td>25% Co-insurance</td>
<td>40% Co-insurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>o Physical Therapy Benefit Maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Limit does not apply to children under age 19 with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Anomalies. The child will also have to be</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in case management and meet Medical Necessity criteria.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The limit for physical therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.
Cost shares you must pay for Covered Services
Please refer to the Section “What is Covered” for additional detail

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Gold Plan In-Network</th>
<th>Silver Plan In-Network</th>
<th>Bronze Plan In-Network</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>0% No Deductible or Co-insurance</td>
<td>0% No Deductible or Co-insurance</td>
<td>0% No Deductible or Co-insurance</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Note:** Preventive care services must meet the requirements of federal and state law. Certain Preventive care services are Covered Services with no Deductible or Co-insurance when you utilize an In-Network Provider and the service is properly coded as preventive care. This means the Plan covers 100% of the Maximum Allowed Amount with no Member cost share for these certain Covered Services provided by an In-Network Provider.

**Radiation Therapy**
- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)
  - 15% Co-insurance after Deductible
  - 20% Co-insurance after Deductible
  - 25% Co-insurance after Deductible
  - 40% Co-insurance after Deductible

- Outpatient Facility Services
  - 15% Co-insurance after Deductible
  - 20% Co-insurance after Deductible
  - 25% Co-insurance after Deductible
  - 40% Co-insurance after Deductible

**Respiratory and Pulmonary Therapy**
- Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)
  - 15% Co-insurance after Deductible
  - 20% Co-insurance after Deductible
  - 25% Co-insurance after Deductible
  - 40% Co-insurance after Deductible

- Outpatient Facility Services
  - 15% Co-insurance after Deductible
  - 20% Co-insurance after Deductible
  - 25% Co-insurance after Deductible
  - 40% Co-insurance after Deductible

  - **Respiratory Therapy Benefit Maximum**
    - 40 visits per Benefit Period
    - In- and Out-of-Network visits combined

**Skilled Nursing Facility**
- Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program)
  - 15% Co-insurance after Deductible
  - 20% Co-insurance after Deductible
  - 25% Co-insurance after Deductible
  - Not Covered

  - **Skilled Nursing / Rehabilitation Services Benefit Maximum**
    - 120 days per Benefit Period
### Cost shares you must pay for Covered Services

Please refer to the Section “What is Covered” for additional detail

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Gold Plan In-Network</th>
<th>Silver Plan In-Network</th>
<th>Bronze Plan In-Network</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Speech Therapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>• Outpatient Facility Services</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
<tr>
<td>o Speech Therapy Benefit Maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40 visits per Benefit Period In- and Out-of-Network visits combined</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The limit for speech therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit, or as mandated by state law for treatment of autism.

<table>
<thead>
<tr>
<th>Surgery</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Temporomandibular and Craniomandibular Joint Treatment</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Care Services</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
</tbody>
</table>

| Vision Exam                                        |                      |                        |                        |                            |
| For routine services                               | 0%                   | 0%                     | 0%                     | Not Covered                |
|   o Vision Exam Benefit Maximum                    |                      |                        |                        |                            |
|                                                   | 1 Exam every 24 months |

**Note:** Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit when provided by an In-Network Provider and properly coded as Preventive Care.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Gold Plan In-Network</th>
<th>Silver Plan In-Network</th>
<th>Bronze Plan In-Network</th>
<th>Out-of-Network (All Plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For non-routine services</td>
<td>15% Co-insurance after Deductible</td>
<td>20% Co-insurance after Deductible</td>
<td>25% Co-insurance after Deductible</td>
<td>40% Co-insurance after Deductible</td>
</tr>
</tbody>
</table>

**Note:** Eye refraction testing is covered. Vision hardware, includes one pair of glasses or contact lenses following cataract surgery within 12 months of the surgery.

<table>
<thead>
<tr>
<th>Wigs</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0% Co-insurance after Deductible</td>
<td>0% Co-insurance after Deductible</td>
<td>0% Co-insurance after Deductible</td>
<td>Same as In-Network</td>
</tr>
</tbody>
</table>

- **Wigs Benefit Maximum** $750 per Lifetime, subject to Medical Necessity

**Note:** Wigs are excluded regardless of the reason for the hair loss, with the exception of hair loss relating to cancer/chemotherapy treatment.
HOW THE HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN WORKS

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

HRA consists of the following components:

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

<table>
<thead>
<tr>
<th>SHBP Coverage Tier</th>
<th>Gold Base HRA Credits</th>
<th>Gold HRA after completion of all 2018 incentive actions (base HRA credits + earned well-being credits)</th>
<th>Silver Base HRA Credits</th>
<th>Silver HRA after completion of all 2018 incentive actions (base HRA credits + earned well-being credits)</th>
<th>Bronze Base HRA Credits</th>
<th>Bronze HRA after completion of all 2018 incentive actions (base HRA credits + earned well-being credits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>400</td>
<td>880</td>
<td>200</td>
<td>680</td>
<td>100</td>
<td>580</td>
</tr>
<tr>
<td>You + Child(ren)</td>
<td>600</td>
<td>1,080</td>
<td>300</td>
<td>780</td>
<td>150</td>
<td>630</td>
</tr>
<tr>
<td>You + Spouse</td>
<td>600</td>
<td>1,560</td>
<td>300</td>
<td>1,260</td>
<td>150</td>
<td>1,110</td>
</tr>
<tr>
<td>You + Family</td>
<td>800</td>
<td>1,760</td>
<td>400</td>
<td>1,360</td>
<td>200</td>
<td>1,160</td>
</tr>
</tbody>
</table>

**Note:** SHBP Members will have access to a variety of Sharecare (formerly known as Healthways) tools, activities and services to earn additional well-being incentive credits. To learn more, please see the Sharecare Section of this SPD, visit [www.BeWellSHBP.com](http://www.BeWellSHBP.com), or call Sharecare’s Member Services on the back of your Member ID Card.

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

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

3. **Earn additional well-being credits.** Members and/or covered spouses can earn additional well-being credits for their HRA. Sharecare administers the 2018 action-based incentives. To earn these well-being credits...
credits, complete the well-being activities between January 1 and November 30, 2018. Please see the Sharecare Section of this SPD.

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

Regarding Your SHBP Health Reimbursement Arrangement (HRA):

- The HRA credits placed in your HRA will depend on the option elected by the Member. For example if enrolled in the Bronze Option at the beginning of the Benefit year in the single tier, SHBP will fund 100 credits in this account.

- If you are a new hire or newly enrolled in the HRA Option within the plan year, the HRA credits in your HRA will be pro-rated based on the number of months remaining in the Benefit year. The Deductible and Out-of-Pocket Maximum are not pro-rated.

- If you experience a qualifying event and increase your coverage tier, your new HRA credits will be pro-rated based on the number of months remaining in the Benefit year.

- If you experience a qualifying event and decrease your coverage tier, the amount placed in your HRA for that plan year will not change.

- If you or an enrolled Dependent(s) experience a qualifying event which results in coverage under a new contract, the entire Deductible and Out-of-Pocket Maximum under the new contract will have to be met (This does not apply in cases where you are a surviving spouse or a dependent staying on the HRA plan after the retired subscriber moves to Medicare Advantage). See the Eligibility and Enrollment Provisions document posted at www.shbp.georgia.gov for more information. All HRA balances, Deductibles and Out-of-Pocket Maximums will remain with the prior contract. Pro-rated HRA credits will be deposited into the new contract based on the elected coverage tier and months remaining in the current plan year. Deductibles and Out-of-Pocket Maximums are not pro-rated.

- If your employment terminates for any reason, the credits in your HRA will be forfeited, unless you elect COBRA coverage and remain under the same contract. See the Eligibility and Enrollment Provisions document posted at for COBRA coverage details. The HRA credits will remain available to assist you in paying your Out-of-Pocket costs while COBRA coverage is in effect.

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

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

Required Information for Filing an Out-of-Network Claim
When you request reimbursement from your HRA, you must complete the HRA Claim Form and attach the itemized documentation as described on that form. The form is available on www.bcbsga.com/shbp or by calling the BCBSGa Member Services number on your Member ID Card.
HOW YOUR MEDICAL PLAN WORKS

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

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

**In-Network Services and Providers**

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

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

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

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

For services from In-Network Providers:
1. You will not be required to file any claims. In-Network Providers will file claims for Covered Services for you (You will still need to pay applicable Deductibles, and Co-insurance). You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this SPD.
2. Precertification will be done by the In-Network Provider. See the Section “Getting Approval for Benefits” for further details.

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

**After Hours Care**

If you need care after normal business hours, your Doctor may have several options for you. Call your Doctor’s office for after hour’s instructions if you need care in the evenings, weekends, or during a holiday, and cannot wait until the office reopens. If you’re not sure where to go for care and your Doctor is not available, you can also call the 24/7 Nurse Line at 866-787-6361. Refer to Office Visits and Physician Services in the What is Covered section for other covered services.

Remember, if you are having an Emergency, call 911 or go to the nearest Emergency Room.

**Out-of-Network Services and Providers**

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

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

**How to Find a Provider in the Network**

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

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

**Note:** An In-Network Provider during an office visit may utilize, order, or refer you to other Providers for additional services. To maximize your In-Network benefits, your In-Network provider must utilize or refer you to other In-Network Providers. Examples include, but are not limited to, laboratory (known as reference laboratory services) and radiology. A Reference Laboratory is a freestanding lab outside the Physician’s office such as Labcorp. For more information, call the BCBSGa Member Services number on the back of your Member ID Card.

If you need help choosing a Doctor, call the BCBSGa Member Services number on the back of your Member ID Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with BCBSGa to help with your needs. Please note that BCBSGa has several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your ID Card or call Medical Claims Administrator to find out which network this Plan uses.
Your Cost-Shares
See the “Definitions” Section for a better understanding of each type of cost share as shown in the Schedule of Benefits table.

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

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

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Identification Card (ID card)
BCBSGa will give each Member enrolled in the Plan an ID Card. When you get care, you must show your Member ID Card. Only covered Members have the right to receive services under this Plan. If anyone gets services or Benefits they are not entitled to under the terms of this SPD, he/she must pay for the actual cost of the all services.
GETTING APPROVAL FOR BENEFITS

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

The Medical Claims Administrator, BCBSGa, will use clinical coverage guidelines, such as medical policy, preventive care clinical coverage guidelines, and other applicable policies to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. BCBSGa reserves the right to review and update these clinical coverage guidelines. If you have any questions about the information in this Section, call the BCBSGa Member Services number on the back of your Member ID Card.

Types of Requests

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

- **Precertification** – A required prospective review of a service, treatment, admission or continued stay review for a determination of benefit coverage.

- **Predetermination** – An optional, voluntary prospective or a request for a benefit coverage determination regarding a service or treatment. The Predetermination coverage review will include a review to see if there is a related clinical coverage guideline or medical policy, the service meets the definition of Medical Necessity under this Plan, is it Experimental / Investigational as that term is defined in this Plan, or a Benefit Exclusion under the Plan.

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

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

<table>
<thead>
<tr>
<th>Who Is Responsible for Getting Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services provided by an In-Network Provider, including BlueCard Providers in the service areas of various Anthem Blue Cross and Blue Shield States: CA, CO, CT, IN, KY, ME, MO, NH, NV, NY, OH, NA, WI</td>
</tr>
<tr>
<td>Services provided by any Out-of-Network or Non-Participating Provider.</td>
</tr>
</tbody>
</table>
You are entitled to ask for and receive, at no cost, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Member ID Card.

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

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

Just because BCBSGa exempts a process, Provider, or claim from the standards which would apply, does not mean that BCBSGa will do so in the future for any other Provider, claim or Member. BCBSGa 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 the BCBSGa Member Services on the back of your Member ID Card.

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

**Request Categories**

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

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

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

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

**Decision and Notice Requirements**

BCBSGa will review requests for benefits according to the timeframes listed on the next page. Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on your Member Identification Card for additional information.

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

If more information is needed to make a decision, BCBSGa will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to complete the review. If BCBSGa 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.

BCBSGa will give notice of its determination (as required by state and federal law) by either:

- **Verbal**: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider, or
- **Written**: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider, and you / your authorized representative

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

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

**Services Requiring Precertification/Prior Approval**

**Note**: To obtain Precertification or Prior Approval, Members must call the BCBSGa Personal Health Coach team at 855-668-6442 for the certain services to be provided by either an In-Network or an Out-of-Network provider. This is a dedicated line to obtain Precertification/Prior Approval. Read your SPD carefully regarding Covered Services. If you are not sure if a service is covered and requires Precertification, please call Member Services at 855-641-4862. Services that require Precertification/Prior Authorization include:

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

- Ambulance non-emergency transport (except ground ambulance transfers from one acute facility to another)
- Ankle replacement
- Applied Behavioral Analysis (ABA) Therapy
- Back pain (chronic), percutaneous neurolysis
- Blepharoplasty, blepharoptosis repair, and brow lift
- Bone Growth Stimulator: Electrical or Ultrasound
- Breast procedures including reduction mammoplasty, reconstructive surgery, implants and other breast procedures
- Cardiac resynchronization therapy for heart failure treatment
- Cardiac transcatheter closure of patent foramen ovale and left atrial appendage for stroke prevention
- Cardiac ventricular septal defect transmyocardial/perventricular device closure
- Cardio-reduction, partial left ventriculectomy
- Cardioverter defibrillators, implantable (ICD) and wearable
- Clinical Trials
- Cochlear implants and auditory brainstem implants
- Communication/speech generating devices, augmentative and alternative (ACC)
- Cosmetic and reconstructive services of the head and neck; trunk and groin
- Cosmetic and reconstructive services, skin related
- Dental care due to accident or injury
- Durable Medical Equipment
- Endoscopy, Capsule
- Functional electrical stimulation (FES); threshold electrical stimulation (TES)
- Genetic testing for cancer susceptibility, BRCA Genetic Testing Program
- Hearing aids, bone-anchored and implantable, middle ear
- Heart monitors, real-time remote
- Hip Replacement Surgery
- Home Health Care Nutritional/Enteral Therapy
- Home Health Care; Home Infusion
- Home phototherapy for neonatal hyperbilirubinemia
- Hyperbaric oxygen therapy (systemic/topical)
- Hyperhidrosis
- Hysterectomy, Abdominal and vaginal
- Infusion pumps, implantable
- Infusion pumps, insulin, external (portable) continuous
- Intervertebral discs, cervical artificial and lumbar artificial
- Knee Arthroplasty, Total and Bicompartmental
- Mandibular/maxillary (orthognathic) surgery
- Nasal surgery for the treatment of obstructive sleep apnea (OSA) and radiofrequency ablation of nasal turbinates for nasal obstruction with or without OSA
- Obstructive sleep apnea treatment in adults
- Obstructive sleep apnea; oral, pharyngeal and maxillofacial surgical treatment
- Oral Surgery
- Oscillatory devices for airway clearance including high frequency chest compression (Vest™ airway clearance system) and intrapulmonary percussive ventilation (IPV)
- Penile prosthesis implantation
- Powered mobility devices
- Prosthesis, microprocessor controlled lower limb
- Prosthetic devices, myoelectric upper extremity
- Radiofrequency volumetric tissue reduction (RFVTR) of the soft palate, uvula, or tongue base (including Coblation and Somnoplasty)
- Sacral nerve stimulation as treatment of neurogenic bladder secondary to spinal cord injury
- Sacroiliac joint fusion
- Septoplasty
- Shoulder Arthroplasty
- Sinuplasty, balloon
- Sleep disorder testing
- Specialty Medications/Injectable Medications
- Spinal artificial intervertebral discs
- Spinal cord stimulators (SCS), implanted
- Spinal percutaneous and endoscopic procedures (vertebroplasty, kyphoplasty, sacroplasty)
- Spinal stenosis, implanted devices
- Spine and joints other than the knee, manipulation under anesthesia
- Spine surgery lumbar – laminectomy, fusion and artificial intervertebral disc
- Standing frames
- Stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT)
- Temporomandibular disorders
- Transplant evaluation, pre-determination, inpatient admits
- Uterine fibroid ablation, MRI guided high intensity focused ultrasound
- Uvulopalatopharyngoplasty
- Vagus nerve stimulation
- Varicose vein (lower extremity) treatment
- Wheeled mobility devices, ultra lightweight manual wheelchairs

**Behavioral Health Services**
Inpatient and Outpatient Mental Health/Substance Abuse (In-Network/Out-of-Network) within 24 hours of admission

**Note:** Residential Treatment Centers, methadone clinics/treatment for Mental Health/Substance Abuse are not covered.

**AIM Specialty Health Services**
- Radiology – Diagnostic Services (CT scan, CTA, MRA, MRI, PET Scan)
- Cardiac – Diagnostic Services (Echocardiography or Nuclear Cardiology)
- Sleep Testing and Therapy Services
- Certain Radiation Therapy

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

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

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

The following are some examples of services (but not limited to):
- Pre-Surgery/Pre-admission Testing
- Infertility Services (Once diagnosed, treatment is not covered)
- Treatment by assistant surgeons or co-surgeons
- Treatment of TMJ
• Allergy testing
• Occupational therapy
• Speech therapy
• Physical therapy
• Reconstructive services

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

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

Late Notice Penalty Post-service Review
For In-Network Providers, late notice penalties do not apply to Members.

For Out-of-Network Providers, the Member late notice penalty is 50% of the Maximum Allowed Amounts for Covered Services.
VOLUNTARY INCENTIVE PROGRAMS

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

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

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

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

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

If you meet program criteria and agree to participate, BCBSGa will assist the Member to meet their identified health care needs. This is reached through contact and team work with Members and/or their chosen representative, treating Doctor(s), and other Providers.

In addition, BCBSGa may help with coordinating care with existing community-based programs and services to meet Members’ needs. This may include giving the Member information about external agencies and community-based programs and services.

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

Participate in the Personal Health Coach program
If you or another covered family member have certain conditions, the Personal Health Coach can help you better manage your health and follow your doctor’s care plan.
Specific conditions include, but are not limited to:

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

They can also help you:

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

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

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

Also for Members who sign up www.livehealthonline.com/ will receive a lactation video and postpartum support for mothers at no additional cost.

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

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

- Diabetes
- Coronary Artery Disease (CAD)
- Asthma

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

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

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

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

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

Additional details regarding Covered Services are described below:

**Allergy Services**

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

**Ambulance Services (Air, Water, and Ground)**

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

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick /injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
  - From your home, the scene of accident or medical Emergency to a Hospital;
  - Between Hospitals, including when BCBSGa 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 BCBSGa requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
  - Between a Hospital and an approved Facility.

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

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

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

- Doctor’s office or clinic;
- morgue or funeral home.

**Important Notes on Air Ambulance Benefits**

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

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

**Hospital to Hospital Transport**

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

**Autism Services Expansion**

Your Plan includes coverage for the treatment of neurological deficit disorders as required by Law. Coverage is limited to medically necessary Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD). Coverage will be provided to a maximum benefit of $35,000 per year per approved member (through age 20). Applicable Deductibles and/or Co-insurance may apply to all covered services.

**Cardiac Rehabilitation**

Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.

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

**Chemotherapy**

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

**Chiropractic Services / Osteopathic Manipulation Therapy**

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

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

**Clinical Trials including Cancer Clinical Trial Programs for Children**

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

Benefits are limited to the following trials:

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

i. The Department of Veterans Affairs

ii. The Department of Defense

iii. The Department of Energy

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

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

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

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

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

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

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

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

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

Dental Services & Oral Surgery (for the treatment of injury or illness)
Note: This Plan provides limited coverage for dental services and oral surgery.

Preparing the Mouth for Medical Treatments
Your Plan includes coverage for dental services to prepare the mouth for surgical procedures that are necessary to repair (or replace) damage done as a result of oral cancer or treatment for oral cancer such as radiation treatment and chemotherapy or as required in preparation for a transplant.

Covered Services in these circumstances include:

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

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

Other Dental Services
Hospital or Facility charges and anesthesia needed for dental care are covered if the Member meets any of the following conditions:
- The Member is under the age of 7
- The Member has a chronic disability that is attributable to a mental and/or physical impairment which results in substantial functional limitation in an area of the Member’s major life activity, and the disability is likely to continue indefinitely; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care

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

Benefits are also limited to certain oral surgeries including:
- Reconstructive surgical procedures (including dental implants) for the repair of sound, natural teeth or tissue that were damaged as a result of oral cancer or treatment for oral cancer such as chemotherapy or radiation treatment and other cancer related treatments with prior approval by the Precertification unit.
- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part
- Oral / surgical correction of accidental injuries as indicated in the above “Dental Services”
- Treatment of non-dental lesions, such as removal of tumors and biopsies
- Incision and drainage of infection of soft tissue (except for odontogenic cysts or abscesses are not covered)
- Removal of only fully impacted wisdom teeth

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

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:
- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a health care professional who is licensed, registered, or certified under state law.

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

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

Diagnostic Services
Your Plan includes benefits for tests or procedures to find or to 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
- Tests ordered before a surgery or hospital admission

Other Imaging Services
Benefits are also available for advanced imaging services, which include but are not limited to:
- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

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

Dialysis / Hemodialysis & Specialty Care Physician
Evaluation and Management of acute renal failure and chronic (end-stage) renal disease, including
treatment by hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal
dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include
dialysis treatments in an outpatient dialysis Facility and home dialysis and training for you and the person
who will help you with home self-dialysis.

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

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

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

Durable Medical Equipment and Medical Devices
Your Plan includes Benefits for durable medical equipment and medical devices when the equipment meets
the following criteria: is meant for repeated use and is not disposable; is used for a medical purpose and is of
no further use when medical need ends; is meant for use outside a medical Facility, is only for use of the patient;
is made to serve a medical use; and is ordered by a Provider.

Medically necessary Covered Services include:
- The purchase-only equipment and devices (e.g., crutches and customized equipment)
- Purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs)
• Continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by BCBSGa. The Plan may limit the amount of coverage for ongoing rental of equipment. The Plan may not cover more in rental costs than the cost of simply purchasing the equipment.
• The repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair
• Oxygen and equipment for its administration
• Cochlear implants
• Breast pumps (as described in the “Preventive Care” Section)
• Medical equipment and medical supplies for the treatment of diabetes
• Hearing aids (as described in the “Schedule of Benefits” Section)

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

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

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

Medically necessary Covered Services include:
• The fitting, adjustments, repairs and replacements of prosthesis
• Artificial limbs and accessories
• One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes
• Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women’s Health and Cancer Rights Act
• Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care
• Restoration prosthesis (composite facial prosthesis)
• Wigs needed after cancer/chemotherapy treatment, limited to the $750 lifetime maximum shown in the “Schedule of Benefits” Section

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

Emergency 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 on the following page.

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; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.
Such conditions include, but are not limited to, chest pain, stroke, poisoning, serious breathing problems,
unconsciousness, severe burns, cuts, uncontrolled bleeding, seizures, and such other acute conditions as
may be determined to be Emergencies by BCBSGa.

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

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

Medically Necessary services will be covered whether you receive care from an In-Network or
Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an
In-Network service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor call BCBSGa
as soon as possible. BCBSGa will review your care & determine if the Hospital admission and length of stay
is a covered service. See “Getting Approval for Benefits” for more details. If you or your Doctor do not call
BCBSGa, 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 BCBSGa
agrees to cover it as an Authorized Service.

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

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

Covered Services include but are not limited to:
• Intermittent skilled nursing services by an R.N. or L.P.N.
• Medical / social services
• Diagnostic services
• Nutritional guidance
• Training of the patient and/or family/caregiver
• Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
• Medical supplies
• Durable medical equipment
• Home health services. Home health services are limited to skilled nursing or therapy services provided
in the home that are prescribed to achieve specific health care goals. Covered home health services
must be provided by professional health personnel such as registered nurses, licensed practical nurses,
occupational therapists, physical therapists, speech pathologists or audiologists. The prescribing
provider must update the home health treatment plan at least once every 30 days to define the continued
need for skilled intervention. Home health services do not include custodial care. Custodial care generally
provides assistance in performing activities of daily living (e.g., assistance walking, transferring in and out of bed, bathing, dressing, using the toilet, preparation of food, feeding and supervision of medication that usually can be self-administered). Custodial care essentially is personal care that does not require the attention of trained medical or paramedical personnel.

- **Home Infusion Therapy**– includes Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See Section “Drugs Administered and Billed by a Provider as a Medical Service” for more details.

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

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

Covered Services include:

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

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, 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. A Covered Transplant Procedure is defined as the determination by BCBSGa, 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.

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

- **Blue Distinction Center for Transplant (BDCT)** The Blue Distinction Centers for Specialty CareSM is a program administered by the Blue Cross and Blue Shield Association that identifies quality providers for transplant services nationwide. Each Center has been selected through a rigorous evaluation of clinical
data that provides insight into the facility's structures, processes, and outcomes of care.

- **Centers of Medical Excellence (CME)** The CME designation is awarded by Anthem to those programs meeting the participation requirements for Anthem’s transplant network and all other future specialty networks developed by Anthem. Each Center has been selected through a rigorous evaluation of clinical data that provides insight into the facility’s structures, processes, and outcomes of care.

**Precertification and Prior Approval for Transplant Services**

Precertification and Prior Approval are required (except for kidney & cornea) before the Plan will cover Benefits for a transplant. To maximize your Benefits, call BCBSGa’s Transplant Department as soon as you think you may need a transplant, before evaluation and/or workup, and to talk about your benefit options. The Transplant department will help you maximize your Benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Member Services phone number on your Member ID Card and ask for the transplant coordinator. Your Doctor must certify, and BCBSGa must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to BCBSGa as soon as possible to start this process. Failure to obtain Precertification will result in a denial of Benefits.

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

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

**Donor Benefits for Transplant Services**

Benefits for an organ donor are as follows:

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

**Transportation and Lodging for Transplant Services**

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

You must send itemized receipts for transportation and lodging costs to BCBSGa when claims are filed. Call BCBSGa for complete information.

For lodging and ground transportation Benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code, but not to exceed $10,000 per transplant episode. The Internal Revenue Code can be found at [www.irs.gov](http://www.irs.gov) that also lists the standard mileage rate for use of an automobile (1) for medical care described in § 213.
Non-Covered Services for transportation and lodging for transplant services include, but are not limited to: child care, mileage within the medical transplant Facility city, rental cars, buses, taxis, or shuttle service (except as specifically approved by BCBSGa), frequent flyer miles, coupons, vouchers or travel tickets, prepayments or deposits, services for a condition that is not directly related to or a direct result of the transplant, phone calls, laundry, postage, entertainment, travel costs for donor companion/caregiver, return visits for the donor for a treatment of an illness found during the evaluation, and meals.

NOTE: Travel and Lodging reimbursement is also available for eligible members when receiving cancer treatment at an eligible Cancer Resource Service Center of Excellence* (COE). The member’s home address must be at least 75 miles from the COE (200 miles for airfare). All eligible expenses are reimbursed after the Expense Forms have been completed and submitted with the appropriate receipts. All other guidelines follow those outlined above under Transportation and Lodging for Transplant Services.

Inpatient Facility Services

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

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

Benefits for ancillary services include:

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

Inpatient Professional Services
Covered Services include:

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

Maternity and Reproductive Health Services
Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:
• Professional and Facility services for childbirth in a Facility or the home, including the services of an appropriately licensed nurse midwife
• Routine nursery care for the newborn during the mother’s normal Hospital stay, including circumcision of a covered male Dependent
• Prenatal and postnatal services
• Medically Necessary fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed

If you are pregnant on your effective date and your Provider is not In-Network, you must fill out a Continuation of Care Request Form and send it to BCBSGa to have covered services processed at the In-Network level. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate postpartum period. If you change doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.

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

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

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

Abortion Services
Benefit includes an abortion only when the life of the mother is at risk.

Infertility Services
Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Diagnostic services are covered to rule out a diagnosis, but once diagnosed; treatment of infertility is not covered. This Plan does not offer any form of infertility treatment.

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

Mental Health and Substance Abuse Services
Covered Services include the following:
• Inpatient Services in a Hospital or any Facility that must be covered by law. Inpatient Benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification or outpatient facility, such as partial hospitalization programs and intensive outpatient programs.
• Outpatient Services including office visits and treatment in an outpatient department of a Hospital and office visits.

You can get Covered Services from the following Providers:
• Psychiatrist

2018 SHBP BCBSGa HRA Summary Plan Description 42
• Psychologist
• Neuropsychologist
• Licensed clinical social worker (L.C.S.W.)
• Mental health clinical nurse Specialist
• Licensed marriage and family therapist (L.M.F.T.)
• Licensed professional counselor (L.P.C)
• Any agency licensed to provide these services, when they must be covered by law

Office Visits and Physician Services
Office Visits for medical care (including second surgical opinion) to examine, diagnose, and treat an illness or injury.
Walk-In Doctor’s Office for services limited to routine care and the treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.
Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that a Doctor visit in the home is different than the “Home Care Services” benefit described earlier in this SPD.
Retail Health Clinic 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.

Online Visits (LiveHealth Online)
When available in your area, your coverage will include medical and behavioral online visits from a LiveHealth Online contracted Provider through your smartphone, tablet, or computer. Medical online visits are available 24/7 without an appointment. LiveHealth Online Psychology appointments are available 7 days a week, 7 a.m. to 11 p.m. for adults and children ages 10 and older and are subject to appointment availability. See the Schedule of Benefits for applicable Co-insurance. Visit www.livehealthonline.com/ or download the free app.

Please note that LiveHealth Online providers are not able to prescribe controlled substances and lifestyle drugs. Prescriptions written must meet state regulations and SHBP formulary and prior authorization guidelines.

Also available to Members who sign up for the BCBSGa Future Moms program can receive a lactation video and postpartum support for mothers at no additional cost.

NOTE: Online visits are not covered from Providers other than those contracted with LiveHealth Online. LiveHealth Online can be used for common health conditions such as the flu, cold, sinus infections, stress, and family health questions; however, for an emergency, call 911.

Non-Covered Services include but are not limited to communications used for:
• Reporting normal lab or other test results
• Office appointment requests
• Billing, insurance coverage or payment questions
• Requests for referrals to Physicians outside the online care panel
• Benefit Precertification
• Physician to Physician consultation

Outpatient Facility Services
Your Plan includes Covered Services in an:
• Outpatient Hospital
• Freestanding Ambulatory Surgical Facility
• Mental Health / Substance Abuse Facility

2018 SHBP BCBSGa HRA Summary Plan Description
• Other Facilities approved by BCBSGa

Benefits include Facility and related (ancillary) charges, when proper, such as:
• Surgical rooms and equipment
• Prescription Drugs including specialty drugs
• Anesthesia and anesthesia supplies and services given by the Hospital or other Facility
• Medical and surgical dressings and supplies, casts, and splints
• Diagnostic services
• Therapy services

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

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

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

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

Benefits for physical, speech or occupational therapy as detailed below are allowed up to the maximum visits listed in the “Schedule of Benefits”. Covered Services include:

• Physical therapy – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
  
  **Note:** Physical Therapy benefits may be extended beyond 40 visits for children up to age 19 with Congenital Anomalies. The child will also have to be enrolled in case management and meet medical necessity criteria.

• Speech therapy and speech-language pathology (SLP) services – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat swallowing skills or communication to correct a speech impairment.

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

Preventive Care

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

Covered Services include the following:
1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples
include screenings for:
- Breast cancer
- Cervical cancer
- Colorectal cancer
- High blood pressure
- Type 2 Diabetes Mellitus
- Cholesterol
- Child and adult obesity

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

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

4. Preventive care and screening as listed in the guidelines supported by the Health Resources and Services Administration, including:
   - Contraceptives, sterilization procedures and counseling.
   - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
   - Gestational diabetes screening

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

You may call BCBSGa Member Services at the number on your Member ID Card for more details about these services or view the federal government’s web sites:
https://www.healthcare.gov/what-are-my-preventive-care-benefits,
http://www.ahrq.gov, and
http://www.cdc.gov/vaccines/acip/index.html

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

2018 SHBP BCBSGa HRA Summary Plan Description 45
Radiation Therapy
Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.

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

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

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

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

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

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

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

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

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

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services
Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular
joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.

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

**Urgent Care Services**
An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include, but are not limited, to earache, sore throat, and fever.

Benefits are available for urgent care such as:
- X-ray services
- Tests such as flu, urinalysis, pregnancy test, rapid strep
- Lab services
- Stitches for simple cuts
- Draining an abscess

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

Benefits do not include glasses and contact lenses except as listed in the “Prosthetics” benefit.
WHAT IS NOT COVERED

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

1. **Abortion** Services, supplies, Prescription Drugs, and other care provided for elective voluntary abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions performed to save the life of the mother.

2. **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond the Medical Claims Administrator’s control, BCBSGa will make a good faith effort to give you Covered Services. BCBSGa will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

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

3. **Administrative Charges**
   - Charges for the completion of claim forms,
   - Charges to get medical records or reports,
   - Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

4. **Alternative/Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   - Acupuncture,
   - Holistic medicine,
   - Homeopathic medicine,
   - Hypnosis,
   - Aromatherapy,
   - Massage and massage therapy ,
   - Reiki therapy,
   - Herbal, vitamin or dietary products or therapies,
   - Naturopathy,
   - Thermography,
   - Orthomolecular therapy,
   - Contact reflex analysis,
   - Bioenergial synchronization technique (BEST),
   - Iridology-study of the iris,
   - Auditory integration therapy (AIT),
   - Colonic irrigation,
   - Magnetic innervation therapy,
   - Electromagnetic therapy,
   - Neurofeedback / Biofeedback.

5. **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

6. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
7. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

8. **Chiropractic Services / Osteopathic Manipulation Therapy** Services include, but are not limited to:
   - Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning, and prevents loss of that functioning, but which does not result in any additional improvement.
   - Nutritional or dietary supplements, including vitamins
   - Cervical pillows
   - Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.
   - Manipulation Therapy is not covered when given in the home

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

10. **Contraceptives** Non-prescription contraceptive devices, unless required by law.

11. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No Benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
    
    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or surgery to restore function of a body area that has been altered by illness or trauma.

12. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

13. **Crime** Treatment of injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

14. **Custodial Care, Convalescent Care and Rest Cures.** This Exclusion does not apply to Hospice services.

15. **Dental Treatment** Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as:
   - Removing, restoring, or replacing teeth;
   - Medical care or surgery for dental problems (unless listed as a Covered Service in this SPD);
   - Services to help dental clinical outcomes.

    Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

    This Exclusion does not apply those services required by the law to be covered.

16. **Dental Services** Dental services not described as Covered Services in this SPD.

17. **Donor Breast Milk**

18. **Educational Services** or supplies for teaching, vocational, or self-training purposes, including Applied Behavior Analysis (ABA), except as listed in this SPD for prior approved ABA for Autism Spectrum Disorders for covered dependents ages 10 and under.
19. **Experimental or Investigational Services or supplies** that are found to be Experimental or 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 BCBSGa deems it to be Experimental / Investigative.

20. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight. This Exclusion does not apply to lenses needed after a covered eye surgery.

21. **Eye Exercises, Orthoptics and vision therapy.**

22. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

23. **Family Members** Services prescribed, ordered, referred by or given by a Member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

24. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
   - Cleaning and soaking the feet.
   - Applying skin creams to care for skin tone.
   - Other services that are given when there is not an illness, injury or symptom involving the foot.

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

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

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

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

28. **Gynecomastia** Treatment of benign gynecomastia (abnormal breast enlargement in males).

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

30. **Home Care**
   - Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a home health care Provider.
   - Private duty nursing.
   - Food, housing, homemaker services and home delivered meals.

31. **Infertility Treatment** Testing or treatment related to infertility except for diagnostic services and procedures to correct an underlying medical condition. Non-covered service includes assisted reproductive technologies (ART) or the diagnostic tests and Prescription Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT). Fertility treatments such as artificial insemination and in-vitro fertilization, egg and sperm storage/preservation for future pregnancy. Other Infertility procedures not specified in this SPD are not Covered Services.
32. **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

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

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

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

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

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

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

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

39. **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except for the extraction of fully impacted wisdom teeth.

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

41. **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy. Pharmacy Benefits are administered separately. See the “Prescription Drug Pharmacy Benefits” table in this Section and the “Outpatient Prescription Drug Rider” Section of the SPD for more information.

42. **Private Duty Nursing** Private Duty Nursing Services.

43. **Prosthetics** for sports or cosmetic purposes.

44. **Residential Treatment Centers and methadone clinics/treatment** for Mental Health/ Substance Abuse.
45. **Routine Physical Exams** Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, or for school activities.

46. **Sex Change** Services and supplies for a sex change, gender reassignment and/or the reversal of a sex change.

47. **Sexual Dysfunction** Services or supplies for male or female sexual problems.

48. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

49. **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.

50. **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).

51. **Tobacco Cessation Programs** to help you stop using tobacco if the program is not affiliated with BCBSGa or Sharecare (SHBP Wellness Program Administrator).

52. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

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

54. **Vision Services** Vision services not described as Covered Services in this SPD.

55. **Weight Loss Programs**, whether or not under medical supervision. This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

56. **Weight Loss Surgery** Bariatric surgery. Non-covered services includes but are not limited to Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partially digested food from the duodenum to the jejunum, the Section of the small intestine extending from the duodenum), or gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.
MEDICAL CLAIMS PAYMENT

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

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

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

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

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

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

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

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

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

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

For non-emergency 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 BCBSGa:

1. An amount based on BCBSGa Out-of-Network fee schedule/rate, which BCBSGa has established in its discretion, which BCBSGa 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 BCBSGa; (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, BCBSGa 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 BCBSGa or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

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

Unlike In-Network Providers, Out-of-Network Providers may bill and collect for the amount of the Provider’s charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will result in lower Out-of-Pocket costs to you.

Member Services is also available to assist you in determining your plan’s Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider’s charges to calculate your out-of-pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim
will be based on the services rendered at the time of service and the claim submitted by the Provider.

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

**Member Cost Share**

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

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

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

In some instances you may have a higher cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Outpatient 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 may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider’s charge.

**Authorized Services for Out-of-Network Providers**

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

Your plan also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact BCBSGa until after the Covered Service is rendered. Please contact Member Services to obtain authorization or to request information on Authorized Services.

**Claims Review**

BCBSGa has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider’s failure to submit medical records with the claims that are under review in these processes.

**Notice of Claim & Proof of Loss**

After you get Covered Services, BCBSGa 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, BCBSGa 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 BCBSGa did not receive your claim within ninety (90) calendar days, but it is sent in as soon as reasonably possible and within one year after the ninety (90) day period ends (i.e. within fifteen (15) months), you may still be able to get Benefits.

**Note:** Additional or missing information on claims initially received as stated above can be submitted to BCBSGa up to twenty-four (24) months after you receive Covered Services.

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

**Medical Claim Forms**

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

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

**Member’s Cooperation**

You will be expected to complete and submit to the Plan all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers’ Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

**Payment of Benefits**

BCBSGa may make benefit payments directly to In-Network Providers for Covered Services. If you use an Out-of-Network Provider, BCBSGa 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. Once a Provider performs a Covered Service, BCBSGa will not honor a request to withhold payment of the claims submitted. 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.

**Inter-Plan Programs and Out-of-Area Services**

Blue Cross and Blue Shield Healthcare Plan (BCBSHP) has relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain Covered Services outside of BCBSHP’s service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program, and may include negotiated National Account arrangements available between BCBSHP and other Blue Cross and Blue Shield Licensees.
Typically, when accessing care outside BCBSHP’s service area, you will obtain care from other Providers that have a contractual agreement (i.e., “participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating Providers. BCBSHP’s payment practices in both instances are described below.

BCBSHP covers only limited healthcare services received outside of BCBSHP corporate parent’s Service Area. As used in this section, “Out-of-Area Covered Healthcare Services” include Emergency Care and urgent care obtained outside the geographic area BCBSHP’s corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These “other services” must be provided or authorized by your Primary Care Physician (“PCP”).

**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.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Cost share amount.

**Emergency Care Services:** If you experience a Medical Emergency while traveling outside the BCBSHP Service Area, go to the nearest Emergency Care Facility or Urgent Care Center.

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

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

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

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

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

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

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

Exceptions

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

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider’s service(s) will be considered non-network care, and you may be billed the difference between the charge and the Maximum Allowed Amount. Call the BCBSGa Member Services on your Member ID Card or go to www.bcbsga.com/shbp for more information about such arrangements.
COORDINATION OF BENEFITS WHEN MEMBERS ARE INSURED UNDER MORE THAN ONE PLAN

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

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

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

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

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

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

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

Primary Plan/Secondary Plan means the "Order of Benefit Determination Rules" states whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering you.
-When This Plan is the Secondary Plan, the Benefits are determined after those of the other plan and may be reduced because of the other plan’s Benefits.
-When This Plan is the Primary Plan, the Benefits are determined before those of the other Plan and without considering the other Plan’s Benefits.
-When there are more than two Plans covering you, This Plan may be a Primary Plan in relationship to one or more other plans and may be a Secondary Plan in relationship to a different plan or plans.
Order of Benefit Determination Rules
When you have duplicate coverage, claims will be paid as follows:

- **Automobile Insurance** - Medical Benefits available through automobile insurance coverage will be determined before this Plan.

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

- **Dependent Child/Parents Not Separated or divorced** - Except as stated below, when this program and another program cover the same child as a Dependent of different persons, called “parents”:
  1. The Benefits of the program of the parent whose birthday falls earlier in a year are determined before those of the program of the parent whose birthday falls later in that year.
  2. If both parents have the same birthday, the Benefits of the program which covered the parent longer will be determined before those of the program which covered the other parent for a shorter period of time.

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

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

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

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

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

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

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

Reduction in this Program’s Benefits
The Benefits of this Plan will be reduced when the sum of:

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

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

Right to Receive and Release Needed Information
Certain facts are needed to apply these rules. BCBSGa has the right to decide which facts it needs. BCBSGa may need to get facts from or give them to any other organization or person, as necessary to coordinate Benefits. BCBSGa 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, BCBSGa 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, BCBSGa may recover the excess from one or more of:

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

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

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

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

Your Duties:

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

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

You have the right to:

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

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health Benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician (Doctor), also called a PCP.
- Treat all Doctors, health care Providers and staff, your case manager and Personal Health Coach 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 BCBSGa, your Doctors and other health care professionals the information needed to help you get the best possible care and all the Benefits you are entitled to. This may include information about other health and insurance Benefits you have in addition to your coverage with the Plan.

For more information call BCBSGa Member Services or go to www.bcbsga.com/shbp.
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, BCBSGa, follows the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, BCBSGa’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 BCBSGa’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:

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

Mandatory First Level Appeals (Grievances)

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

For pre-service claims involving urgent/concurrent care

You may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including BCBSGa’s decision, can be sent between BCBSGa 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 BCBSGa at the number shown on the back of your Member ID Card and provide at a minimum:

- the Member ID number for the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider’s name;
- the service or supply for which approval of Benefits was sought; and
- reason the appeal should be processed on a more expedited basis.
All other requests for Appeals (Grievances)
Should be submitted in writing by the Member or the Member’s authorized representative, except where the acceptance of oral Appeals (Grievances) is otherwise required by the nature of the appeal (e.g., urgent care). You or your authorized representative must submit a request for review to:

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

Upon request BCBSGa will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. “Relevant” means that the document, record, or other information:
- was relied on in making the benefit determination;
- was submitted, considered, or produced in the course of making the benefit determination;
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan’s policy or guidance about the treatment or benefit relative to your diagnosis.

BCBSGa 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, BCBSGa will provide you, free of charge, with the rationale.

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

How Your Appeal will be Decided
When BCBSGa considers your appeal, BCBSGa 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:** BCBSGa 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:** BCBSGa will notify you of the outcome of the appeal within fifteen (15) days after receipt of your request for appeal.
- **If you appeal a post-service claim:** BCBSGa will notify you of the outcome of the appeal within thirty (30) days after receipt of your request for appeal.

Appeal Denial
If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from BCBSGa will include all of the information set forth in the above Section “Notice of Adverse Benefit Determination”.

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

**Note:** The mandatory second level appeal can be bypassed upon request if the initial first level appeal is deemed experimental and investigational. In these situations the next appeal level can be independent External Review.

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

A request for an External Review must be in writing unless BCBSGa determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted in the first and second level appeals, as applicable. 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 appeal or while simultaneously pursuing an expedited appeal through BCBSGa’s internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including BCBSGa’s decision, can be sent between BCBSGa and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact BCBSGa at the number shown on the back of your Member ID Card and provide at least the following information:
- the Member ID number for the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider’s name;
- the service or supply for which approval of Benefits was sought; and
- reason the appeal should be processed on a more expedited basis.

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

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

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

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

BCBSGa reserves the right to modify the policies, procedures and timeframes in this Section upon further clarification from the Department of Health and Human Services and Department of Labor.
GENERAL PROVISIONS

Form or Content of SPD
No agent or Covered Person of the Medical Claims Administrator, BCBSGa, 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
BCBSGa 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 BCBSGa’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 BCBSGa’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, BCBSGa will pay primary Benefits and Covered Person will pay the unsubsidized premium.

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

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

Modifications
The Plan Administrator may change the Benefits described in this SPD and the Member will be informed of such changes as required by law. This SPD shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Plan Administrator, or by mutual agreement between BCBSGa 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 BCBSGa nor the Plan Sponsor are responsible for the actual care you receive from any person. This SPD does not give anyone any claim, right, or cause of action against BCBSGa or the Plan Sponsor based on the actions of a Provider of health care, services, or supplies.

**Policies and Procedures**
BCBSGa, 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.

BCBSGa has the authority, in its discretion, to institute from time to time, utilization management, care management or disease management in certain designated geographic areas. These pilot initiatives are part of BCBSGa'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 (BCBSHP) 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 BCBSGa, 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**
BCBSGa 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. BCBSGa’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.
BCBSGa 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. BCBSGa will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. BCBSGa may not give you notice of overpayments made by the Plan or you if the Recovery method makes providing such notice administratively burdensome.

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

Fraud
Fraud is knowingly and willfully defrauding any health care benefit program by misrepresentation of facts resulting in unauthorized benefits, payments or gains to an individual or entity. Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member’s coverage. If you believe you’ve found fraud, call our fraud hotline at 800-831-8998. Or, you can call the BCBSGa Member Services number on the back of your Member ID Card.

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

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

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

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

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

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

Appeals (Grievance)
An adverse benefit determination that You have the right to appeal. Please see the “Your Right to Appeal” Section.

Assignment of Benefits (AOB)
A method where the person receiving medical benefits assigns the payment of those benefits to a physician or hospital.

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

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

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

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

Centers of Excellence (COE) Network
A network of health care facilities, which have been selected to give specific services to Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have a Center of Excellence Agreement with the Medical Claims Administrator.
Co-insurance
Your share of the cost for Covered Services that is a percent of the Maximum Allowed Amount. You normally pay Co-insurance after you meet your Deductible. For example, if your Plan lists 20% Co-insurance on medical service, and the Maximum Allowed Amount is $100, your Co-insurance would be $20 after you have met your Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Co-insurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

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

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

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

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

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

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

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

Examples of Custodial Care include:

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

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


**Deductible**
The amount you must pay for Covered Services before Benefits begin under this Plan. For example, if your Deductible is $1,500, your Plan does not pay until you meet the $1,500 Deductible. The Deductible may not apply to all Covered Services. Please see the “Schedule of Benefits” for details.

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

**Doctor**
See definition “Physician.”

**Effective Date**
The date your coverage begins under this Plan.

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

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

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

**Excluded Services (Benefit Exclusion)**
Health care services your Plan doesn’t cover.

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

Medical and scientific evidence means:

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

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

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

Health Plan or Plan
See definition “State Health Benefit Plan”

Home Health Care Agency
A Facility, licensed in the state in which it is located, that:
   • Gives skilled nursing and other services on a visiting basis in your home; and
   • Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Doctor.

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

Hospital
A Provider licensed and operated as required by law which has:
   • Room, board and nursing care;
   • A staff with one or more Doctors on hand at all times;
   • 24 hour nursing service;
   • All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
   • 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:
   • Nursing care
   • Rest care
   • Convalescent care
   • Care of the aged
   • Custodial Care
   • Educational care
   • Subacute care
   • Treatment of alcohol abuse
   • Treatment of drug abuse

Identification Card (ID Card)
The latest Member ID Card given to you will show your identification and group numbers, the type of coverage you have, and the date coverage became effective.
In-Network Provider
A Provider that has a contract, either directly or indirectly, with the Medical Claims Administrator or another organization, to give Covered Services to Members through negotiated payment arrangements.

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

Maximum Allowed Amount
The maximum payment that the Medical Claims Administrator will allow for Covered Services. For more information, see the “Claims Payment” Section.

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

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

The Medical Claims Administrator considers a service Medically Necessary if it is:
1. Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient’s condition;
2. Compatible with the standards of acceptable medical practice in the United States;
3. Not provided solely for your convenience or the convenience of the Doctor, health care Provider or Hospital;
4. Not primarily Custodial Care;
5. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis; and
6. Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member’s illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

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

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

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

Note: Out-of-Network Benefits apply when Covered Services are rendered by a Non-Preferred Provider.
Out-of-Network Provider
A Provider that does not have an agreement or contract with the Claims, or the Medical Claims Administrator’s subcontractor(s), to give Covered Services to Members under this Plan. You will often get a lower level of Benefits when you use Out-of-Network Providers. For Out-of-Network Providers, the plan does not accept assignment of Benefits. You will receive a payment of Benefits and it will be your responsibility to pay that to the Out-of-Network Provider.

Out-of-Pocket Maximum
The maximum amount, including your yearly Deductible and Co-insurance, you may have to pay each year with your own money for covered health services. If you reach the Out-of-Pocket Maximum, your eligible expenses are covered 100% by the plan for the remainder of the plan year. The Out-of-Pocket Maximum is higher for Out-of-Network services.

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

Physician (Medical Doctor)
Includes the following when licensed by law:
- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.

Plan
The State Health Benefit Plan

Plan Administrator
The Georgia Department of Community Health, SHBP Division. References to “we”, “us”, and “our” in this SPD are to the Department of Community Health, SHBP Division.

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

Plan Year
January 1 to December 31

Plan Sponsor
The Georgia Department of Community Health

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

Precertification
See Section “Getting Approval for Benefits” for details.

Predetermination
See Section “Getting Approval for Benefits” for details.

Prescription Drug
A medicine made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:
- Compounded (combination) medications, containing two or more ingredients, all of which must be covered ingredients by the plan, and at least one ingredient must require a prescription. Compounded medications cannot essentially be a copy of commercially available drug products
- Insulin, diabetic supplies, and syringes.

Note: Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by BCBSGa. The Prescription Drug Benefits retail, mail order and specialty drug programs are administered by CVS Caremark. Refer to the Outpatient Prescription Drug Rider in this SPD.
Primary Care Physician ("PCP")
A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

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

Prior Authorization
See “Getting Approval for Benefits” Sections for details.

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

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

Recovery
See "Subrogation and Reimbursement" Section for details.

Referral
See “How Your Plan Works” Section for details.

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

Service Area
The geographical area where you can received Covered Services.

Skilled Nursing Facility
A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by the Medical Claims Administrator. A Skilled Nursing Facility gives the following:
1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

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

Special Enrollment
A period of time in which eligible people or their Dependents can enroll after the initial enrollment, due to a qualifying event such as marriage, birth, adoption, etc. See the separate SPD “Eligibility and Enrollment
Specialist (Specialty Care Physician / Provider or SCP)
A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

State Health Benefit Plan (SHBP)
The State Health Benefit Plan is comprised of three self-insured plans established by Georgia law: 1) for State employees (O.C.G.A. § 45-18-2), 2) for teachers (O.C.G.A. § 20-2-881), and 3) for non-certified public school employees (O.C.G.A. § 20-2-911). Covered Services are the same under all three self-insured plans and they are usually referred to together as the State Health Benefit Plan.

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

Urgent Care Center
A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.
Well-Being Program Description – Be Well SHBP
For the past four (4) years the Be Well SHBP Wellness program administrator has been Healthways. Healthways is now owned by Sharecare. State Health Benefit Plan (SHBP) will continue to sponsor Well-Being Programs through the Wellness Program Administrator, Sharecare. Starting in 2018, your health and well-being journey will have a new look and feel and Sharecare will provide you with support, new tools and redesigned lifestyle management information you need to improve your own health and well-being. The new Be Well SHBP Wellness program is a mobile first option that you will find enhances your ability to engage in the program.

Well-Being Incentive Credits
Feel better by earning up to 480 well-being incentive credits. These well-being incentive credits will help to offset eligible medical and pharmacy expenses and help you save. Complete the RealAge test at www.BeWellSHBP.com and participate in other healthy actions to earn the well-being incentive credits.

Well-being incentive credits will not be awarded until after the completion of the RealAge test.

For details or questions go to www.BeWellSHBP.com or call 888-616-6411.

NOTE: All actions must be completed and appropriate documentation (including the 2018 Physician Screening Form) submitted and received by Sharecare between January 1, 2018 and November 30, 2018. It is your responsibility to ensure your information is complete and all documentation (including the 2018 Physician Screening Form) is received by Sharecare by November 30, 2018. After your physician has completed and signed your Physician Screening Form, you are allowed to fax the form to Sharecare if necessary.

In 2018, you and your covered spouse are each eligible to receive a well-being reward of up to 480 well-being incentive credits when you are enrolled in Blue Cross and Blue Shield of Georgia (BCBSGa) and complete the well-being activities below between January 1, 2018 and November 30, 2018. That is a family total of 960 well-being incentive credits.

<table>
<thead>
<tr>
<th>What to Do</th>
<th>What You will Earn</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess Your Health - Complete the RealAge test</strong></td>
<td><strong>Earn 240 well-being incentive credits</strong></td>
</tr>
<tr>
<td>A confidential, online questionnaire that will take about 20 minutes to</td>
<td><strong>Note</strong>: Incentive credits cannot be awarded until completion of the RealAge</td>
</tr>
<tr>
<td>complete.</td>
<td>test. Biometrics, Telephonic Coaching and Online Pathways taken before completion</td>
</tr>
<tr>
<td><strong>Know Your Numbers – Complete a Biometric Screening</strong></td>
<td>of the RealAge test can only be applied to incentive credits upon RealAge test</td>
</tr>
<tr>
<td>(Credits to be awarded after the RealAge test is completed)</td>
<td>completion.</td>
</tr>
<tr>
<td>You have two options: through your physician using the 2018 Physician</td>
<td></td>
</tr>
<tr>
<td>Screening Form or at an SHBP-sponsored biometric screening event.</td>
<td></td>
</tr>
<tr>
<td>What to Do</td>
<td>What You will Earn</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Take Action (Credits to be earned after the RealAge test is completed)</strong></td>
<td><strong>Earn up to 240 well-being incentive credits</strong></td>
</tr>
<tr>
<td>Complete the coaching pathway, online pathway, or a combination of both</td>
<td><strong>NOTE:</strong> You may complete as many coaching calls as you like in a month; however, a maximum of one call in a calendar month qualifies you for the 60 well-being incentive credits.</td>
</tr>
<tr>
<td><strong>Telephonic Coaching Pathway</strong></td>
<td><strong>NOTE:</strong> Incentive credits cannot be awarded until completion of the RealAge test. Telephone calls completed or green days earned before completion of the RealAge test can only be applied to incentive credits upon RealAge test completion.</td>
</tr>
<tr>
<td>• Actively engage in telephonic coaching. Earn 60 well-being incentive credits for one completed coaching call per calendar month. You can earn 60 well-being incentive credits up to 4 times, for a maximum of 240 well-being incentive credits.</td>
<td></td>
</tr>
<tr>
<td><strong>Online Pathway</strong></td>
<td></td>
</tr>
<tr>
<td>• Actively track and make progress. Earn 120 well-being incentive credits when you record 60 Green Days within a 90 day period*. You can earn 120 well-being incentive credits up to 2 times, for a maximum of 240 well-being incentive credits.</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> Well-being incentive credits can be earned by logging 8 Green Day trackers daily within the Sharecare App or on the online platform.</td>
<td></td>
</tr>
</tbody>
</table>

* First opportunity period: January 1, 2018 to March 31, 2018. Second opportunity period: Earn 60 Green Days within 90 consecutive days between April 1, 2018 and November 30, 2018.

**Getting Started**
To get started log onto [www.BeWellSHBP.com](http://www.BeWellSHBP.com) and follow the instructions to register on the Sharecare site and take your RealAge test. You will be asked to enter six registration credentials of First Name, Last Name, Date of Birth, Gender, Zip Code and the last four digits of your Social Security Number (SSN).

**Note:** To access the Sharecare App that is specific to SHBP members, you must go to [www.BeWellSHBP.com](http://www.BeWellSHBP.com) and sign up first and then you download the App from this site. You can then log on to the Sharecare App via your smartphone or through your computer.

**Well-being Incentive Credit Rollover Between Plan Options and Medical Claims Administrators**
All unused well-being incentive credits earned while participating in the SHBP Well-Being Program called Be Well SHBP will rollover whether you remained enrolled in your current Plan Option and medical claims administrator or changed to another Plan Option and/or medical claims administrator.

This means no matter which Plan Option you select (excluding TRICARE Supplement), you will not forfeit any unused well-being incentive credits you have earned.

**Note:** Unused well-being incentive credits will rollover in April of 2018. This allows 2017 Well-being Incentive credits to be used to pay your out-of-pocket expenses for 2017 claims filed after December 31, 2017. There is a date limitation to when you may use the 2017 rollover credits for reimbursement. Only eligible medical expenses incurred after the rollover in April 2018 will qualify for reimbursement using the 2017 well-being incentive credit rollover funds. Expenses for services incurred from January to March 2018 are not eligible for reimbursement from 2017 rollover credits. However, until your 2017 credits roll over, your 2018 HRA credits funded by SHBP and any 2018 well-being incentive credits earned and available at the time claims are received by your medical claims administrator may be used for those expenses during this time period.
2018 Well-Being Program Features

The Be Well SHBP well-being program, administered by Sharecare, offers comprehensive well-being tools, resources, services, and incentives to support your goals for health and well-being. This mobile first resource will be customized to your personal needs. If you want to take big steps toward improved well-being or just a small step in the right direction, Sharecare can help. The program is confidential, voluntary and offered at no additional cost to you and your covered spouse. The type of support you will receive:

BIOMETRIC SCREENING
Access to private screening events with a health care professional that offers a current view of your health and advises you of potential risks for developing certain conditions.

RealAge test
The Sharecare RealAge test is a confidential assessment that guides you through a series of questions designed to gauge how fast you’re aging based on your lifestyle, genetics, and medical history.

GREEN DAY TRACKER
Sharecare Green Day Tracker (GDT) includes daily trackers, which are core to the RealAge calculation. The trackers include: steps, sleep, stress, relationships, blood pressure, weight, smoking exposure, cholesterol, alcohol, fitness and health, diet, medication adherence, and blood glucose. In order to accomplish a Green Day, you will need to enter data for 8 trackers within the green range daily to improve your RealAge.

WELL-BEING PHONE COACHING
- One-on-one telephonic coaching calls with your personal well-being coach who can help you set goals and keep you on track to achieve your well-being goals.
- Get support, healthy answers and encouragement to eat better, lose weight, stress less, get active, feel happier, improve family nutrition, quit using tobacco or better manage a health condition.
- Sharecare’s well-being coach resource can be used alone or in combination with the health coaching programs offered to you from BCBSGa.

LIVE CHAT
Enables Members to directly outreach to a coach or member services staff.

RESOURCES FOR QUITTING TOBACCO
- Access to an online network of those who have quit or are quitting.
- Phone coaching sessions with a trained counselor.
- Proper completion of the Tobacco Surcharge Removal Requirements enables the removal of the tobacco surcharge.

ONSITE WELL-BEING SUPPORT
- Presentations and demonstrations given at your worksite on a variety of topics including healthy eating, family well-being, increasing physical activity, stress management, preventive care and more.
- Worksite Well-Being ambassadors program to keep you informed and motivated.

GROUPS AND CHALLENGES
- Lets you participate in a community of other people who share similar goals.
- Get group support and encouragement to help inspire you to stick with it and achieve your goals.
Sharecare Well-Being Services

The SHBP website www.BeWellSHBP.com, provides a link to the Sharecare platform. The platform webpage is mobile responsive and includes the features below. The Key components of the Sharecare platform:

• RealAge test: A clinically validated health risk assessment.
• Daily Trackers (Green Days): Engagement data to track key RealAge test health indicators.
• Digital Health Programs: Personalized recommendations, suggested content, targeted insights, and customized messages.
• Content Library: Articles, questions and answers, videos, health topics, and much more.
• AskMD: Evidence-based and customizable symptom checker tool.
• Find-a-Doctor: Members can search for doctors/providers. **Members should always check with their medical claims administrator to confirm the doctor/provider is covered and is in their network.**
• Personal Health Profile: Personal health record where members can access their health history in one place.
• Mobile Application and Smart Phone Technology: The Sharecare App places the power of the Sharecare App in the hands of smart phone users.
• 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.
• Device integration to promote fitness, exercise and health and Well-Being: Members using the Sharecare App can link their own devices to the trackers. Once linked, the device will share its data with the application automatically updating the Green Day Trackers. Members may also rely on their personal cell phone to establish some trackers, not relying on an external devise. Members are responsible for making sure that the information is properly tracked.
• Well-Being Incentive Credits and Rewards Tracking: Your incentive status will be listed under the Rewards section of the Sharecare App or online platform.

**Sharecare RealAge test**
The RealAge test is Sharecare’s clinically-validated health risk assessment that guides you through a series of questions designed to gauge how fast you’re aging based on your lifestyle, genetics, and medical history as well as often overlooked risk factors like relationships and stress. RealAge is your first step to get started with Sharecare, as it helps you understand which of your good and bad habits are impacting your health. From there, Sharecare provides you with content and programs to help you improve your overall health and obtain a younger RealAge. It takes 20 minutes to complete the RealAge test. The answers you provide will not be shared with your employer or SHBP.

**Biometric Screenings**
A Biometric Screening provides an excellent opportunity to know your biometric numbers and what they mean for you. The screening typically takes 10-15 minutes. During a biometric screening event, a health professional will collect measurements, including body mass index (BMI), blood pressure, cholesterol and glucose. In 2018, SHBP Members and covered spouses will have the opportunity to obtain a biometric screening at their personal Physician’s office or at an SHBP-sponsored biometric screening event. For information on biometric screenings please visit www.BeWellSHBP.com or call Sharecare at 888-616-6411.
2018 Physician Screening Form
You may complete your screening with your Physician and utilize an easy-to-use 2018 Physician Screening Form. The form can be accessed through www.BeWellSHBP.com, printed from your computer and taken to your Physician for completion. Each individual will need to log in and enter their first and last name as it appears on their Member ID card, date of birth, zip code and gender to pre-populate the form. Any 2018 Physician Screening Forms not pre-populated will not be processed. The 2018 Physician Screening Form processing oversight is handled by Sharecare.

If the 2018 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, you will need to work with your Physician’s office to ensure that the form is signed and submitted by the deadline of November 30, 2018. If your form is signed, but only partially completed, your form will be processed as is and will only show results for the data provided. Well-being incentive credits will only be awarded when all of the results are complete. For information on Physician Screening Forms, please visit www.BeWellSHBP.com or call 888-616-6411.

It is your responsibility to ensure your information is complete and all documentation (including the 2018 Physician Screening Form) is received by Sharecare by November 30, 2018. After your physician has completed and signed your Physician Screening Form, you are allowed to fax the form to Sharecare if necessary.

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: exercise, healthy eating, stress management, tobacco cessation and weight management, as well as other risk areas.

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

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

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

Well-Being Incentive Tracking
Through the Rewards section of the Sharecare App or online platform, Members can see up to date statuses regarding well-being incentive credits. The well-being incentive credits will be available the month after completion of the activity. This includes completion of the RealAge test and biometric screening, enrollment and engagement in Well-Being Coaching, and ongoing participation in the Sharecare App or online platform.

View your well-being incentive credits under your Rewards section of the Sharecare App or online platform. Members can perform a screen print function to show evidence they completed the required activities for program completion.
Timelines for Actions to be Posted
The Sharecare RealAge test will be live on January 1, 2018. Immediately after taking the RealAge test you can begin earning Green Days and on your way to personalized messaging and much more meant just for you. You have until November 30, 2018 to complete the activities to earn well-being incentive credits for 2018.

The 2018 action-based incentive credits will be earned as the action is completed and will be available in your incentive account within 30 days after completion of the activity.

You can earn 60 well-being incentive credits per calendar month for completing one telephonic coaching call in a calendar month. These will only be awarded after the completion of the RealAge test and can be earned up to four times, for a maximum of 240 well-being incentive credits.

You can earn 120 well-being incentive credits when you record 60 Green Days within a 90-day period using the green day trackers within the Sharecare App or online platform. A Green Day can be earned by tracking critical health factors that impact your RealAge: stress, activity, sleep, relationships, weight, blood pressure, blood glucose, cholesterol, smoking, drinking, diet, fitness and medications. With each key health factor rated on the five-point color scale from green to red, your goal is to be “in the green” for 8 factors in each calendar day to earn what we call “a green day”.

- Your first 90-day period must be tracked beginning on 1/1/18 and ending on 3/31/18. Starting 4/1/18, you can begin tracking your second Green Day period which will be on an individual, rolling period. A rolling 90-day period means “any 90 consecutive days” without a specific start or end date, between 4/1/2018 and 11/30/18 being the latest possible date to complete the incentive credit.
  - Example: A member earns 120 well-being incentive credits by earning a green day 60 times between the time period of 1/1/18 and 3/31/18. Then the member earns an additional 120 well-being incentive credits by earning 60 green days between the time period of 5/1/18 and 7/29/18.

OR

- You can track your two 90-day periods within the 4/1/18 - 11/30/18 timeframe if you did not receive your 120 incentive credits for tracking during the first 90-day period of 1/1/18 thru 3/31/18.
  - Example: A member does not earn 60 green days between the time period of 1/1/18 and 3/31/18. No well-being incentive credits will be awarded for this first time period. This member earns 120 well-being incentive credits by earning a green day 60 times between 4/1/18 and 6/29/18. Then the member earns an additional 120 well-being incentive credits by earning a green day 60 times between 8/1/18 and 10/29/18.

Actions must be completed between January 1, 2018 and November 30, 2018 to earn the 2018 well-being incentive credits.

When the biometric screening is completed at a 2018 SHBP-sponsored biometric screening event or with your Physician in 2018 using the 2018 Physician Screening Form, and the data is successfully completed as outlined within all documents, you will earn 240 well-being incentive credits if you also completed your RealAge test within the Sharecare App or on the online platform.

If your well-being incentive credits are not properly displaying in the Rewards section of the Sharecare App or online platform please call Sharecare at 888-616-6411.
Tobacco Cessation

Tobacco Cessation Telephonic Well-Being Coaching
Resources for quitting tobacco that are available to eligible Members, covered spouses and dependents 18 years and older:

• Access to an online network of those who have quit or are quitting
• Phone coaching sessions with a trained counselor
• E-mail tips offering motivation and encouragement
• Access to Nicotine Replacement Therapy coverage – see Pharmacy Benefits Administrator section
• Self-refer into coaching or online support via www.BeWellSHBP.com

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 and TRICARE). These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Telephonic Coaching Program.

Go to www.shbp.georgia.gov to access the tobacco surcharge removal policies and forms. These policies allow you to have the tobacco surcharge removed by completing the tobacco surcharge removal requirements through Sharecare.

If you and your enrolled Dependents who use tobacco complete the telephonic or online tobacco cessation Well-Being Coaching program and the RealAge test, you will be able to avoid the tobacco surcharge for the entire year. This means that any surcharge paid in 2018 may be refunded after the completion of the tobacco surcharge removal requirements. The tobacco surcharge removal requirements must all be completed in 2018. Contact Sharecare at 888-616-6411 for more information.

If you think you may be unable to complete the tobacco surcharge removal requirements, you may qualify for an opportunity to avoid the tobacco surcharge by different means. Contact Sharecare at 888-616-6411 and Sharecare 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.
2018 Well-Being Incentive Credits Appeal Process

If you or your covered Spouse, or both, are advised that your 2018 Well-Being Incentive Credits were not obtained, you may appeal this decision directly to Sharecare. Appeals, along with the requested documents, must be submitted by 5:00 pm, ET **January 31, 2019**. Well-Being Incentive Credits Appeals submitted after this date will be denied.

**Level I – Well-Being Incentive Credits Appeals**
To file a Well-Being Incentive Credits Appeal, complete all applicable sections on the Level 1 - 2018 Well-Being Incentive Credits Appeal Form located at [www.BeWellSHBP.com](http://www.BeWellSHBP.com), sign and date the form. If the 2018 Well-Being Activity in question was not satisfied due to circumstances beyond your control, you should explain why in the space provided on the Level 1 - 2018 Well-Being Incentive Credits Appeal Form. Examples of “circumstances beyond your control” include, but are not limited to, the following: long term hospital stay and hospice stay.

You should submit the form, along with the supporting documentation, to the email, fax or mailing address located on the Level 1 - 2018 Well-Being Incentive Credits Appeal Form. An example of appropriate supporting documentation includes:

- A copy of the completed 2018 Physician Screening Form and confirmation that it was sent to Sharecare by the November 30, 2018 deadline (if applicable).
- A copy of the Know Your Numbers Form as proof on onsite screening participation upon completion at a SHBP-sponsored screening event.
- Print screen or take a snapshot of the incentive status when activities through the Sharecare App or online platform are complete.

**Level II – Formal Appeal**
If your 2018 Well-Being Incentive Credits Appeal is denied, you may file a Formal Appeal, which must be postmarked within fifteen (15) calendar days following the date of the 2018 Level 1 Well-Being Incentive Credits Appeal decision. To file a Formal Appeal, you must complete the Level 2 – 2018 Well-Being Incentive Credits Appeal Form and attach a copy of the 2018 Level 1 Appeal decision, along with any supporting documentation. The Level 2 - 2018 Well-Being Incentive Credits Appeal form is located at [www.BeWellSHBP.com](http://www.BeWellSHBP.com) under incentives. Instructions are included on the form.

Generally, a decision by the Formal Appeal committee will be issued within thirty (30) calendar days following receipt. The written notice of the decision by the Committee is the final step in the administrative proceedings and will exhaust all administrative remedies.

Please forward all written requests for Formal Appeals along with a completed Level 2 2018 Well-Being Incentive Credits Appeal Form to the email, fax or mailing address located on the Appeal Form. The appeal form is available at [www.BeWellSHBP.com](http://www.BeWellSHBP.com) under incentives.
Sharecare Definitions

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

Sharecare RealAge test
The RealAge test is Sharecare’s clinically-validated health risk assessment that guides you through a series of questions designed to gauge how fast you’re aging based on your lifestyle, genetics, and medical history as well as often overlooked risk factors like relationships and stress. The RealAge test is your first step to get started with Sharecare, as it helps you understand which of your good and bad habits are impacting your health. From there, Sharecare provides you with content and programs to help you improve your overall health and obtain a younger RealAge. It takes 20 minutes to complete the RealAge test. The answers you provide will not be shared with your employer or SHBP.

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

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

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

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

Sharecare App
The Sharecare App is a health and wellness engagement platform that provides personalized information, programs and resources to improve your health. It provides personalized information to you based on your response to the RealAge test.

Health Profile
Provides an overview of all your health data in one place based on the results of your RealAge test, trackers, find a doctor, AskMD, and with your permission, can include data ingested from your biometrics and claims.

Green Day Tracker
Sharecare Green Day Tracker (GDT) includes daily trackers, which are core to the RealAge calculation. The trackers include, steps, sleep, stress, relationships, blood pressure, weight, smoking exposure, cholesterol, alcohol, fitness and health, diet, medication adherence, and blood glucose. In order to accomplish a Green Day, you will need to enter data for 8 trackers within the green range daily to improve your RealAge.

End of the Wellness Program Administrator Section
OUTPATIENT PRESCRIPTION DRUG RIDER

This Rider to the Summary Plan Description (SPD) provides Benefits for outpatient Prescription Drug Products. CVS Caremark administers your Prescription Drug Pharmacy Benefits. Because this Rider is part of a legal document, we want to give you information about this document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the CVS Caremark Pharmacy Definition Section. When we use the words “we,” “us” and “our” in this document, we are referring to Department of Community Health (DCH), State Health Benefit Plan (SHBP) Division. When we use the words “you” and “your,” we are referring to people who are Covered Members.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy, CVS Caremark Mail Order, CVS Specialty or an out-of-network pharmacy.

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

CVS Caremark has been selected to administer the pharmacy benefits for Members and their Covered Dependent(s) enrolled in Blue Cross and Blue Shield of Georgia Non-Medicare Advantage Plan Options for 2018.

Note: This change does NOT mean Members will have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network. Members and their Covered Dependent(s) can continue to use local retail and/or chain pharmacies to obtain their prescription medications. Please visit the CVS Caremark’s pharmacy locator tool to find a network pharmacy near you.

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

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

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

Note: Co-insurance amounts do not go toward the deductible; however, they do go toward the Out-of-Pocket Maximum.
For Prescription Drug Products at a participating Retail Network Pharmacy, you are responsible for paying:
- The applicable Co-insurance or
- The applicable Co-insurance and Ancillary CVS Caremark Charge or
- The Network Pharmacy Usual and Customary Charge, which includes a dispensing fee and may include sales tax for the Prescription Drug Product if this results in a lower price than the applicable Co-insurance.

For Prescription Drug Products from the CVS Caremark Mail Order Pharmacy or CVS Specialty you are responsible for paying:
- The applicable Co-insurance or
- The applicable Co-insurance and Ancillary Charge or
- The Prescription Drug Cost for that Prescription Drug Product if this results in a lower price than the applicable Co-insurance.

Note: For the most up-to-date coverage information (including supply limits, PA requirements, etc.) for Prescription Drug Products that meet the definition of a Covered Health Service, call the CVS Caremark Customer Care number on your Member ID Card or visit info.caremark.com/shbp.

Coverage Policies and Guidelines
Your CVS Caremark 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 2018 Preferred Drug List (PDL). All Covered Outpatient Prescription Drug Products on the PDL are FDA-approved Prescription Drug Products.

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

Your HRA Plan will have Prescription Medications Placed in Tiers.
Prescription medications are categorized within three (3) tiers which are determined by the Pharmacy Benefits Administrator. Each tier is assigned a Co-insurance amount which is determined by the Plan. Please consult the CVS Caremark Preferred Drug List at info.caremark.com/shbp, or call the CVS Caremark Customer Care number on your Member ID Card for the most up-to-date tier status of your medication(s). When you fill a prescription, you pay the Co-insurance at the time the prescription is filled.

The Preferred drug list is developed by CVS Caremark and contains FDA approved prescription medications. This list is developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective. Selection criteria sources include but are not limited to: peer-reviewed literature; recognized compendia; consensus documents; nationally sanctioned guidelines and other publications of the National Institutes of Health, Agency for Healthcare Research and Quality, and other organizations or government agencies; drug labeling approved by the FDA; and input from medical specialty practitioners.

Whether a particular Prescription Drug Product is appropriate for an individual Covered Member is a determination that is made between the Member and their prescribing physician.

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

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

If you do not show your Member ID Card at a Network Pharmacy, you will be required to pay the Full Retail Cost (Usual and Customary Charge) for the Prescription Drug Product at the pharmacy.
If you paid full Retail Cost at the pharmacy and wish to seek reimbursement, you may obtain a prescription drug claim form by calling the CVS Caremark Customer Care number on your BCBSGa Member ID card. Along with the prescription drug claim form, you will need the pharmacy receipt for your prescription including quantity dispensed, drug NDC number, and cost.

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

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

**CVS Specialty**

Specially 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 CVS Caremark website info.caremark.com/shbp. Your prescriptions must be filled through CVS Specialty home delivery program if you have a prescription for one of these products. See “Glossary and Definitions” for definitions of Specialty Prescription Drug Product and Designated Pharmacy. See “What’s Covered-Prescription Drug Benefits” Section for more information on Specialty Prescription Drug Product.

**Note:** Most Specialty drug prescriptions are allowed at least the first fill at a participating network retail pharmacy; however, there are some exceptions. To find out if you are allowed one retail fill for your particular specialty drug, contact CVS Caremark at the number on your card. If you use any pharmacy other than CVS Specialty after the number of allowed retail fills, you will be subject to the entire cost of the medication.

**Limitation on Selection of Pharmacies**

If CVS Caremark determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies and/or providers may be limited. If this happens, CVS Caremark selects your most recently used Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy and/or provider.

**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.

**CVS Caremark Customer Care**

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

- Prescription Claim Appeals MC 109 - CVS Caremark
  P.O. Box 52084
  Phoenix, AZ 85072

**Prescription Drug Disclaimer**

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

CVS Caremark will provide Pharmacy Benefits under the plan for outpatient Prescription Drug Products:

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

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

Benefits for outpatient Prescription Drug Products are available through three types of Network pharmacies: Retail Network Pharmacies; the CVS Caremark Mail Order; and CVS Specialty. You can obtain information about participating Retail Network Pharmacies by calling the toll-free number on the back of your Member ID card, or on the web at info.caremark.com/shbp.

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

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

Supply Limits
With the required Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. You may determine if a Prescription drug has been assigned a supply limit for dispensing by calling the CVS Caremark Customer Care number on the back of your Member ID Card or on the web at info.caremark.com/shbp.

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

Network Pharmacy Prior Authorization or Coverage Review Requirements
When Prescription Drug Products are dispensed at a Network Pharmacy and require Prior Authorization (PA), the prescribing Provider or Pharmacist are responsible for requesting approval from CVS Caremark. If a PA has not been approved or submitted for approval before the Prescription Drug Product is dispensed at a participating Network Pharmacy, then the prescription is not eligible for coverage and you will be required to pay the Full Retail Cost (Usual and Customary Charge) for that prescription at the pharmacy. If a PA is requested within twelve (12) months after the date the prescription was filled and the PA is retroactively approved, then you may request reimbursement from CVS Caremark. The Prescription Drug Products requiring PA are subject to periodic review and modification. You may find out whether a particular Prescription Drug Product requires PA by consulting your PDL through info.caremark.com/shbp or by calling CVS.
Caremark Customer Care at the number on your Member ID Card.

**Note:** Prior Authorization approval will be required before the claim will be considered for reimbursement. If CVS Caremark is notified within twelve (12) months after you pay the Full Retail Cost and the Prior Authorization is denied, you will not be reimbursed.

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

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

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

If you wish to seek reimbursement, you may obtain a prescription drug claim form from CVS Caremark by calling the CVS Caremark Customer Care number on your BCBSGa Member ID Card, or log into info.caremark.com/shbp. Along with the prescription drug claim form, you will need a pharmacy receipt for your prescription and if applicable- an explanation of benefits (EOB) from your primary carrier.

**Requesting Reimbursement for a claim you paid Full Retail Cost**

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

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

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

**Step Therapy Program Requirements**

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

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to Step Therapy requirements through info.caremark.com/shbp or by calling the CVS Caremark Customer Care number on your Member ID Card.

**Clinical Appeal Process**

If a Prior Authorization or quantity limitation request is denied by CVS Caremark, you or your physician may initiate the clinical appeals process. CVS Caremark recommends that a physician initiate an appeal for a denied Prior Authorization decision by CVS Caremark so that all necessary clinical information can be
obtained.

The request/appeal must be submitted in writing (via letter) to CVS Caremark 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:

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 866-443-1172

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

Second-level appeals (an appeal of the first-level appeal decision described above) must be initiated by you or your authorized representative and must be received in writing (via letter). CVS Caremark recommends that a Physician initiate an appeal for a denied first-level appeal decision by CVS Caremark 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 CVS Caremark to the address above. The second-level appeal decision is the final decision under the plan.

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

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

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

**Preventive Care Medications**

Patient Protection Affordable Care Act, Preventive Care Medications, and over-the-counter (OTC) medications are covered as described in the “Prescription Drug Glossary and Definition” in this Section of the SPD. For these Preventive Care Medications to be covered, you must obtain a prescription from your Doctor and any specified requirements. As part of the Patient Protection and Affordable Care Act, certain contraceptive Prescription Drug Products are covered as Preventive Care Medications at no cost to the Member.

You may determine whether a drug is a Preventive Care Medication by calling the CVS Caremark Customer Care on your Member ID Card or through the website info.caremark.com/shbp. You may not be responsible for paying Co-insurance for these Preventive Care Medications.

**Tobacco Cessation Medications**

An 84-day treatment cycle of OTC or prescription tobacco cessation medications is available through a Retail Network Pharmacy at no cost to the member. A prescription is required for coverage. For a list of the covered tobacco cessation medications, go to info.caremark.com/shbp. A total of two (2) 84-day treatment cycles are allowed resulting in a total of 168 day supply per year at no cost to the member.

The Tobacco Cessation Telephonic Coaching program is available to Covered Members age 18 and older to assist them to become tobacco-free. Please see the Tobacco Cessation section in the Wellness Administrator section of this SPD. To enroll in the Tobacco Cessation program, please call Sharecare at
Patient Safety
CVS Caremark monitors for potential safety issues with drug therapy and will communicate alerts to pharmacist at the point-of-sale and directly to the prescribing physicians when appropriate.

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 CVS Caremark at the time of purchase, you can request the pharmacist to electronically file SHBP secondary (see below).

Coordination of Pharmacy Benefits between your Medicare Part D plan and SHBP
- If you have a Medicare Part D plan as primary, each time you go to the pharmacy, present both your Medicare Part D and SHBP Member ID cards.
- When you reach the Medicare Part D coverage gap, you should still present both identification cards and you will pay your SHBP Co-insurance.

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

Coordination of Pharmacy Benefits between your Primary Prescription Drug Plan (PDP) and SHBP
If you have another health plan as primary, each time you go to the pharmacy, present both your primary insurance carrier and BCBSGa Member ID cards.

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

To request a secondary payment from CVS Caremark 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 CVS Caremark Customer Care number on your Member ID Card, or through info.caremark.com/shbp.

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

Note: The amount paid as secondary payor will not exceed the allowable amount payable by the SHBP. Please call the CVS Caremark Customer Care number on your BCBSGa Member ID Card for more details. If you have coverage under two SHBP contracts (cross-coverage or dual coverage), Prescription Drug Benefits provided by the SHBP will not be coordinated. Co-insurance will be required for each filled prescription. If you have coverage under a Medicare Advantage plan, benefits provided by the SHBP pharmacy benefits will not be coordinated.
PHARMACY TYPE AND SUPPLY LIMITS

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

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

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

If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Brand Co-insurance in addition to the difference between the Brand and Generic Drug costs, referred to as Ancillary Charges. This differential will not apply towards your Out-of-Pocket Maximum.

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

Your Co-insurance is determined by the Prescription Drug List (PDL). All Prescription Drug Products on the PDL are assigned to Tier 1, Tier 2 or Tier 3. To determine tier status, view the PDL at info.caremark.com/shbp, or call the CVS Caremark Customer Care number on your ID Card.

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

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

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

Coverage for up to 31-day supply from a Retail Non-Network Pharmacy
In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Pharmacy. If the out of network pharmacy you use bills more than the plan would reimburse for that same drug to a network pharmacy under their contracted rates then you must pay the difference in cost plus your Co-insurance as outlined below.

The following supply limits apply:
- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer’s packaging size or based on supply limits.
- You may obtain up to a three month supply at one time if you pay a Co-insurance for each month supplied.

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

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

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

You must use CVS Specialty to receive coverage for Specialty Prescription Drug Products. In some cases, you may be allowed to obtain one fill of your Specialty Prescription Drug Product from a participating Retail Network Pharmacy. Thereafter, you will be required to use CVS Specialty to continue coverage for your Specialty Prescription Drug Product. If you do not use CVS Specialty, 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. To determine whether your specialty drug is allowed any initial retail fills, contact CVS Caremark at the number on your card.

**Specialty Coverage for up to a 31-day supply from CVS Specialty:**
- **Tier 1:** 15% Min $20, Max $50
- **Tier 2:** 25% Min $50, Max $80
- **Tier 3:** 25% Min $80, Max $125

**Prescription Drug Products from CVS Caremark Mail Order**
The following supply limits apply for Benefits for outpatient Prescription Drug Products dispensed by the CVS Caremark Mail Order:
- 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).

To fill the prescription, you may:
- Mail your prescription(s) along with the required form to CVS Caremark Mail Order
- Ask your Doctor to call 844-345-3241 for instructions on how to fax the prescription. Your Doctor must include your Member ID number.
- Order through the CVS Caremark website after you register at info.caremark.com/shbp.
- Drop off your prescription at your local CVS Retail Pharmacy who will have your prescription filled through the mail order coverage.

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

CVS Caremark offers two ways to obtain up to a 90-day supply of maintenance drugs.
1. Some participating retail pharmacies in our Network allow you to get up to a 90-day supply of maintenance drugs at the home delivery Co-insurance rates. These are called 90-day retail network pharmacies. To determine which participating retail pharmacies pass through the discounted Co-insurance rates for a 90-day supply, visit Info.caremark.com/shbp and click “Find a Local Pharmacy.” Any participating 90-day retail pharmacy will have an icon indicating that the pharmacy has the ability to provide up to a 90 day supply of a maintenance medication. You can also locate participating retail pharmacies on the CVS Caremark mobile app or call CVS Caremark at the number on the back of your Member ID Card.
2. You can use the CVS Caremark Mail Order.
WHAT IS NOT COVERED – PRESCRIPTION DRUG EXCLUSIONS

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

1. Prescriptions that have been prescribed based solely on electronic patient questionnaires or by any other means where there is no proper relationship between the practitioner and patient.
2. Coverage for Prescription Drug Products for the amount dispensed (days’ supply or quantity limit) that exceeds the supply limit.
3. Drugs that are prescribed dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility or Alternate Facility.
4. 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 CVS Caremark to be experimental, investigational or unproven.
5. 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.
6. 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.
7. Any product laws, whether or not a claim for such Benefits is made or payment or Benefits are received.
8. An injectable Prescription Drug Product (including, but not limited to, immunizations and allergy serum) that, due to its characteristics as determined by CVS Caremark, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to flu, Gardasil, and Zostavax vaccines, self-administered injectable medications and Specialty medications covered through your Pharmacy Benefit plan.
9. The cost of labor and additional charges for compounding prescriptions, excluding contractual dispensing fees that Pharmacies charge.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins except the following, which require a prescription: prenatal vitamins, vitamins with fluoride and single-entity vitamins.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
14. Prescription Drug Products when prescribed to treat infertility.
15. Compound drugs which contain any non-covered ingredients and compounds which do not contain at least one ingredient that requires a prescription. Other coverage rules may apply.
16. Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed except for certain preventive OTC drugs – aspirin, fluoride, and folic acid – that require a prescription for coverage.
17. Yohimbine.
18. Mifepr.
20. Growth hormone used for the treatment of short stature in the absence of identified sickness or injury.
21. Specialty Prescription Drugs purchased at a pharmacy that is not a Specialty Designated Pharmacy (except in most cases for the first prescription fill or in some limited cases two prescription fills of the Specialty Prescription Drug, which may be purchased from a Retail Pharmacy).
22. Nutritional supplements, except for those specifically identified as included under the plan. Contact CVS Caremark for a list of covered supplements.
23. Any Prescription Drug Product that is therapeutically equivalent to an OTC drug on CVS Caremark’s OTC equivalent list. Prescription Drug Products that compromise components that are available in OTC form or an equivalent.
FREQUENTLY ASKED QUESTIONS- PRESCRIPTION DRUG

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

Q1: Does this mean I can only go to CVS Pharmacy® for my prescriptions?
A1: This change does NOT mean members will have to go to CVS Pharmacy for their prescriptions. CVS Caremark has a broad pharmacy network. Members and their covered dependent(s) can continue to use local retail and/ or chain pharmacies to obtain their prescription medications. Use CVS Caremark’s pharmacy locator tool to find a network pharmacy near you. See the following questions for specialty medications.

Q2: Where can I go for more information?
A2: Visit the CVS Caremark website at info.caremark.com/shbp or call:

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<thead>
<tr>
<th>Service</th>
<th>Phone</th>
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<tbody>
<tr>
<td>CVS Caremark Customer Care</td>
<td>844-345-3241</td>
</tr>
<tr>
<td>CVS Specialty®:</td>
<td>866-845-6786</td>
</tr>
<tr>
<td>CVS Prior Authorization for Physicians</td>
<td>866-231-6377</td>
</tr>
<tr>
<td>CVS Prior Authorization for Specialty Drugs</td>
<td>866-231-8371</td>
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Q3: What is a preferred drug list?
A3: The CVS Caremark preferred drug list for the State Health Benefit Plan (SHBP) is a list of U.S. Food and Drug Administration (FDA)-approved prescription drugs developed by CVS Caremark to provide coverage for SHBP members. You may pay more out of pocket under your plan for non-preferred drugs (those not listed as preferred on the preferred drug list) than you would for preferred drugs (those listed as preferred on the preferred drug list).

Q4: How do I use my preferred drug list and what are tiers?
A4: Your preferred drug list has different levels of payment, or tiers, for preferred and non-preferred medicines. You may pay:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Description</th>
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<tr>
<td>$</td>
<td>Lowest co-insurance for generic drugs</td>
</tr>
<tr>
<td>$$</td>
<td>Higher co-insurance for preferred brand-name drugs</td>
</tr>
<tr>
<td>$$$</td>
<td>Highest co-insurance for non-preferred brand-name drugs</td>
</tr>
</tbody>
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Your doctor may be able to help you save money by prescribing generic and preferred brand-name drugs, if appropriate, on the preferred drug list. So be sure to bring a copy of the abbreviated preferred drug list with you on every visit to your doctor. You can print a copy of the abbreviated preferred drug list from info.caremark.com/shbp. Please note: The list does not contain a complete list of preferred and non-referred drugs. It only lists the most commonly prescribed drugs. For more information, visit info.caremark.com/shbp to check the price and coverage of medications under your plan. You can also call CVS Caremark Customer Care at 844-345-3241.

Q5: Will the 2018 preferred drug list be different from the current preferred drug list that I have now?
A5: Yes. Effective January 1, 2018, your plan’s preferred drug list (sometimes called a formulary) will have changes. As a result, some preferred medications may become non-preferred, and vice versa. With CVS Caremark, “Tier 1” will include all generic drugs, “Tier 2” will include all preferred brand-name drugs and “Tier 3” will include all non-preferred brand-name drugs. It’s important to note that some medications may move from one tier (co-insurance level) to another. Depending on whether the medication is moving to a higher or lower tier, the amount you pay for that medication may increase or decrease. Visit info.caremark.com/shbp to view your new preferred drug list and find out which medications are preferred. If you are taking a brand-name drug that is about to become non-preferred, you may want to talk to your doctor about a lower-cost option.
Q6: Will the preferred drug list ever change?
A6: CVS Caremark makes updates to its preferred drug list on an ongoing basis. Changes can be made to the preferred drug list on a quarterly basis.

Q7: Will I be informed if my drug changes status on the drug list?
A7: Yes. CVS Caremark will mail a notification letter to you if your drug changes tier status and results in a higher co-insurance cost to you at any point during the year.

Q8: Are any drugs excluded from my preferred drug list?
A8: The only prescription drugs excluded from your preferred drug list are drugs that fall under coverage areas which are not covered by your benefit design; such as drugs used for cosmetic purposes, drugs for weight loss, or drugs covered under the medical benefit through your medical claims administrator. Please refer to your Summary Plan Document (SPD) for additional information about non-covered drugs.

Q9: What is a 90-day retail pharmacy, and how can I find out if the pharmacy I go to is in that 90-day retail network?
A9: Getting up to a 90-day supply at a retail pharmacy is a feature of your prescription benefit, managed by CVS Caremark. With it, you have two ways to get up to a 90-day supply of your maintenance medicine (a medicine you take on an ongoing basis). You can conveniently fill those prescriptions either through CVS Caremark Mail Service Pharmacy™ or at a participating 90-day retail pharmacy. To locate one, visit info.caremark.com/shbp. You can also locate participating pharmacies by calling CVS Caremark at 844-345-3241.

Q10: How do I start using CVS Caremark Mail Service Pharmacy?
A10: Beginning January 1, 2018, choose one of four easy ways:
• Phone: Call CVS Caremark Customer Care at 844-345-3241.
• Online: Visit info.caremark.com/shbp to register and sign in. Follow the guided steps to request a prescription. Once we have your information, we will contact your doctor for a 90-day prescription of your current medicine.
• Fax: Prescriber can fax a mail service order form to 1-800-378-0323.
• Mail: Fill out and return a mail service order form. You can download one at info.caremark.com/shbp, or you can obtain one from CVS Caremark Customer Care at 844-345-3241.

Q11: Which medications can I fill through the CVS Caremark Mail Service Pharmacy?
A11: Mail service is a convenient way to have 90-day supplies of your long-term medications shipped to you at no added cost. Mail service can save you both time and money—you don’t have to worry about making a trip to the pharmacy every 31 days, and 90-day supplies typically cost less than three 31-day supplies. For more information, call CVS Caremark Customer Care.

Q12: Can I get a 90-day supply of my long-term medications at retail for the same price as mail order?
A12: Yes, if you go to a retail store in the CVS Caremark national pharmacy network that has agreed to be part of the 90-day network group then your co-insurance will be the same for the 90-day supply as through mail service.

Q13: Where do I register for CVS Caremark pharmacy services?
A13: Go to info.caremark.com/shbp.

Q14: How long does it take to receive my medications that I order through CVS Caremark mail service?
A14: For new prescriptions, it can take up to 10 days from the day you submit your order for delivery of your medication. Refills are usually delivered within seven days of placing your order. Although CVS Caremark processes the orders within a day or two, the exact delivery day is dependent on the U.S. Postal Service.
Q15: Is there an additional charge for shipping and handling?
A15: No. Medications are shipped by standard service at no cost to you. Express shipping is also available for an additional fee.

Q16: How can I check the status of my refill order?
A16: On or after January 1, 2018, you can check the status of your mail order refill for traditional medications by signing on to Caremark.com. Click “My Account” on the top right of the page, then click “Prescription History and Order Status.” You can also call CVS Caremark Customer Care at 844-345-3241.

Q17: Will I be reminded when it’s time to refill?
A17: Yes. You can sign up for refill reminders in one of three ways:
- Go online to info.caremark.com/shbp.
- Use the CVS Caremark mobile app.
- Call Customer Care at 844-345-3241.

Q18: If I still have refills on my medications with my previous provider, will CVS Caremark handle those refills? Do I need a new prescription from my doctor?
A18: If you still have refills remaining on prescriptions being filled through Express Scripts, these open refills will be transferred to CVS Caremark.

NOTE: Exceptions include controlled substances because these prescriptions, by law, are not allowed to be transferred between prescription providers. Those impacted by this exception will receive a letter in the next couple of weeks explaining the process.

Q19: I have a refill on a medication I obtained through a non CVS Pharmacy®. Do I need to go to a CVS Pharmacy or do anything different to have it refilled?
A19: Your refill information will be maintained by the retail pharmacy in which you originally filled the prescription. You may refill that prescription at the same pharmacy if they participate in the CVS National Pharmacy Network or choose to have it transferred to another pharmacy in our network of more than 68,000 pharmacies nationwide, including chain pharmacies, 20,000 independent pharmacies and more than 9,700 CVS Pharmacy locations (including those inside Target stores). Regardless of which pharmacy you choose to refill your prescription, when refilling on or after January 1, 2018, you will need to present your new BCBSGa member ID card.

Q20: What if I use a pharmacy that is not in the CVS Caremark network?
A20: If you choose to use a pharmacy that doesn’t participate in the CVS Caremark retail network, you’ll be charged the full cost for the medicine and you’ll need to send a claim form to CVS Caremark for reimbursement. Under your plan, your reimbursement will be based on the cost you would have paid if you used a participating retail pharmacy, minus your applicable deductible and/or co-insurance. Be sure to complete the entire claim form, attach the sales receipt showing the price you paid, and send them to CVS Caremark at the address on the form. To download a claim form, log in info.caremark.com/shbp and follow the link to print a form. Forms are also available by calling CVS Caremark Customer Care at the number on your member ID card.

Q21: How can I check that my current pharmacy is in the CVS Caremark Retail Pharmacy Network?
A21: You can visit info.caremark.com/shbp. You can also call CVS Caremark Customer Care at 844-345-3241.

Q22: How can I find out how much my cost is going to be?
A22: You can find out the cost of your drugs by visiting info.caremark.com/shbp or by calling CVS Caremark Customer Care at 844-345-3241.

Q23: What if I want to speak with a pharmacist?
A23: You can speak to a pharmacist 24 hours a day, seven days a week, by calling CVS Caremark Customer Care at 844-345-3241. When you call, you may be asked several questions to verify your identification.
Q24: What can I do on the CVS Caremark website?  
A24: You may access the CVS Caremark website from a link on the SHBP website www.shbp.ga.gov or go to info.caremark.com/shbp to get information about your plan, find participating retail pharmacies near you and see how much certain medicines will cost. After January 1, 2018 you can go to info.caremark.com/shbp to also quickly refill mail service prescriptions, receive timely medication alerts, find potential lower-cost options available under your plan, check order status and ask questions of a pharmacist online. In order to get information specifically about your SHBP plan, you’ll need to register first. Have your new BCBSGa member ID card handy when you sign up.

Q25: How do I download the CVS Caremark mobile app?  
A25: Visit your smartphone’s or tablet’s market or store and search for “CVS Caremark.” It’s free to download and use.

Q26: What is a specialty pharmacy?  
A26: A specialty pharmacy provides injectable, oral and infused medicines. These complex and costly medicines usually require special storage and handling and may not be readily available at a local pharmacy. Sometimes these medications have side effects that require monitoring by a trained pharmacist or nurse. CVS Specialty focuses on providing these medicines while offering excellent customer service and clinical support to you and your caregivers.

Q27: Why should I use CVS Specialty for my specialty medicines?  
A27: As you may know, the cost of prescription drugs has been rising dramatically over the last several years. That’s especially true of specialty medicines. By using CVS Specialty for specialty drugs, your prescription drug benefit can offset some of these high costs. Please Note: Most specialty drugs can be filled one time for a co-insurance at any participating retail pharmacy. After that, the specialty drug must be filled through CVS Specialty to continue to receive coverage; however, there may be some exceptions. To find out whether your specialty drug is covered for one fill at a participating retail pharmacy, contact CVS Caremark at the number on the back of your new BCBSGa member ID card.

Q28: How do I get started with CVS Specialty?  
A28: You can call us at 866-845-6786 and we will help get you started. With your permission, we will fax your doctor to request a new prescription. Or, your doctor can initiate this by sending CVS Caremark your prescription electronically, by fax or by phone. After your doctor provides the prescription to CVS Caremark, one of our patient care representatives will call you to arrange a convenient time to deliver your medicine. CVS Specialty will provide an expected delivery time after CVS Caremark receives the prescription from your doctor and all shipping requirements are met. CVS Caremark uses scheduled delivery service companies at no cost to you, and all packages include most of the supplies you’ll need to properly administer your medicines, also at no charge.

Q29: How much medicine can I receive per specialty prescription?  
A29: You may receive up to a 31-day supply at a time of specialty medicine through CVS Specialty.

Q30: What if I have questions about my specialty medications?  
A30: Visit www.cvsspecialty.com anytime or call CVS Specialty at 866-845-6786 to speak with a representative. At CVS Specialty, you have access to a team of pharmacists and nurses.

Q31: Is there an extra cost to use CVS Specialty services?  
A31: No. CVS Specialty is part of your prescription drug benefit.

Q32: Can I order all my medications from CVS Specialty?  
A32: No. CVS Specialty dispenses only specialty medicines. Any other non-specialty prescriptions sent to CVS Specialty will be transferred to CVS Caremark mail service.
Q33: What is a prior authorization (PA)?
A33: Prior authorization is administered by CVS Caremark to determine whether your use of certain medications meets your plan’s conditions of coverage. In some cases, a prior authorization may be necessary to determine whether a prescription can be covered under your plan. If your prescription requires prior authorization, your doctor can initiate the prior authorization review by calling CVS Caremark at 866-231-6377. CVS Caremark will inform you and your doctor in writing of the outcome.

Q34: Can I find out ahead of time if a medication may need a prior authorization?
A34: Yes. Go to info.caremark.com/shbp and check the cost of your drug. By checking the cost of your drug, you will also be informed of whether a prior authorization or any other requirements are needed for your medication. You may also check the Preferred Drug List posted on the website for your drug which shows any edits required.
PRESCRIPTION DRUG GLOSSARY AND DEFINITIONS

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

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

Brand-name: A Prescription Drug Product that: (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) CVS Caremark identifies as a Brand-name product based on available data resources – including, but not limited to, Medispan – 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 CVS Caremark.

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

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

Designated Pharmacy: A pharmacy that has entered into an agreement on behalf of the pharmacy with CVS Caremark, 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) CVS Caremark identifies as a Generic product based on available data resources – including, but not limited to, Medispan – 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 CVS Caremark.

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

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

Network Pharmacy: A pharmacy that has:
• Entered into an agreement with CVS Caremark 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 CVS Caremark as a Network Pharmacy

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

New Prescription Drug Product: A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:
• The date it is assigned to a tier by the Plan’s Pharmacy Benefits Administrator’s Prescription Drug List

2018 SHBP BCBSGa HRA Summary Plan Description 102
Management Committee, or
- December 31st of the following plan year

**Prescription Drug Cost:** The rate CVS Caremark 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 List (PDL):** A PDL is a list of FDA-approved Brand-name and Generic medications. The PDL is one way you can find out the tier status and specific rules linked to your medication. The PDL lists the most commonly prescribed medications for certain conditions.

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

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

**Preventive Care Medications:** The medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-insurance) as required by applicable law under any of the following:
- with respect to infants, children and adolescents, evidence- informed preventive care provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

You may determine whether a drug is a Preventive Care Medication at info.caremark.com/shbp or by calling CVS Caremark Customer Care at the toll-free telephone number on your Member ID card.

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

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

**Usual and Customary Charge:** The amount that a Pharmacist would charge a cash-paying customer for a prescription.
Legal Notices 2018

About the Following Notices
The following important legal notices are also posted on the State Health Benefit Plan (SHBP) website at www.shbp.georgia.gov under Plan Documents:

Penalties for Misrepresentation
If a SHBP participant misrepresents eligibility information when applying for coverage during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud for indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law. To avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Federal Patient Protection and Affordable Care Act Notices

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

Access to Obstetrical and Gynecological (OB/GYN) Care
You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in 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, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on the back of your Identification Card.

HIPAA Special Enrollment Notice
If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents’ other coverage). However, you must request enrollment within 31 days after your or your Dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly eligible dependent child). Eligible Covered Persons and Dependents may also enroll under two additional circumstances:
• The Covered Person’s or Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
• The Covered Person or Dependent becomes eligible for a subsidy (State Premium Assistance Program).
NOTE: The Covered Person or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination. To request Special Enrollment or obtain more information, call the SHBP Member Services Center at 1-800-610-1863 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 medical and surgical benefits under your Plan Option. Following cancer surgery, the SHBP covers:
• All stages of reconstruction of the breast on which the mastectomy has been performed a symmetrical appearance
• 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 your Plan option, call the telephone number on the back of your Identification Card.

Newborns’ and Mothers’ Health Protection Act of 1996
The Plan complies with the Newborns’ and Mothers’ Health Protection Act of 1996. Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

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 July 25, 2017

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

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

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

Plan “Enrollment Information” and “Claims Information” are Used in Order to Administer the Plan. PHI includes two kinds of information, “Enrollment Information” and “Claims Information”. “Enrollment Information” includes, but is not limited to, the following types of information regarding your plan enrollment: (1) your name, address, email address, social security number and all information that validates you (and/or your Spouse and Dependents) are eligible or enrolled in the Plan; (2) your Plan enrollment choice; (3) how much you pay for premiums; and (4) other health insurance you may have in effect. There are certain types of “Enrollment Information” which may be supplied to the Plan by you or your personal representative, your employer, other Plan vendors or other governmental agencies that may provide other benefits to you. This “Enrollment Information” is the only kind of PHI your employer is allowed to obtain. Your employer is prohibited by law from using this information for any purpose other than assisting with Plan enrollment. “Claims Information” includes information your health care providers submit to the Plan. For example, claims information may include medical bills, diagnoses, statements, x-rays or lab test results. It also includes information you may submit or communicate directly to the Plan, such as health questionnaires, biometric screening results, enrollment forms, leave forms, letters and/or telephone calls. Lastly, it includes information about you that may be created by the Plan. For example, it may include payment statements and/or other financial transactions related to your health care providers.

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

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

Plan Representatives Regularly Use and Share your PHI in Order to Administer the Plan. Plan Representatives may verify your eligibility in order to make payments to your health care providers for services rendered. Certain Plan Representatives may work for contracted companies assisting with the administration of the Plan. By law, these Plan Representative companies also must protect your PHI. HIPAA allows the Plan to use or disclose PHI for treatment, payment, or health care operations. Below are examples of uses and disclosures for treatment, payment and health care operations by Plan Representative Companies and PHI data sharing. Claims Administrator Companies: Plan Representatives process all medical and drug claims; communicate with the Plan Members and/or their health care providers. Wellness Program Administrator Companies: Plan Representatives administer Well-Being programs offered under the Plan; and communicate with the Plan Members and/or their health care providers. Actuarial, Health Care and /or Benefit Consultant Plan Representatives may have access to PHI in order to conduct financial projections, premium and reserve calculations, and financial impact studies on legislative policy changes affecting the Plan. State of Georgia Attorney General’s Office, Auditing Companies and Outside Law Firms: Plan Representatives may provide legal, accounting and/or auditing assistance to the Plan. Information Technology Companies: Plan Representatives maintain and manage information systems that contain PHI. Enrollment Services Companies: Plan Representatives may provide the enrollment website and/or provide customer service to help Plan Members with enrollment matters.
NOTE: Treatment is not provided by the Plan but we may use or disclose PHI in arranging or approving treatment with providers.

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

DCH and Plan Representatives May Make Uses or Disclosures Permitted by Law in Special Situations. HIPAA includes a list of special situations when the Plan may use or disclose your PHI without your authorization as permitted by law. The Plan must track these uses or disclosures. Below are some examples of special situations where uses or disclosures for PHI data sharing are permitted by law. These include, but are not limited to, the following: Compliance with a Law or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law or to prevent a serious threat to health and safety. Public Health Activities: The Plan may give PHI to other government agencies that perform public health activities. Information about Eligibility for the Plan and to Improve Plan Administration: The Plan may give PHI to other government agencies, as applicable, that may provide you or your dependents benefits (such as state retirement systems or other state or federal programs) in order to get information about your or your dependent’s eligibility for the Plan, to improve administration of the Plan, or to facilitate your receipt of other benefits.

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

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

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.
Right to Inspect and Obtain a Copy of your Information, Right to Ask for a Correction: You have the right to obtain a copy of your PHI that is used to make decisions about you. If you think it is incorrect or incomplete, you may contact the Plan to request a correction. Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of all special uses and disclosures. Right to Ask for a Restriction of Uses and Disclosures or for Special Communications: You have the right to ask for added restrictions on uses and disclosures, but the Plan is not required to agree to a requested restriction, except if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and pertains solely to a health care item or service that you or someone else on your behalf has paid in full. You also may ask the Plan to communicate with you at a different address or by an alternative means of communication in order to protect your safety. Right to a Paper Copy of this notice and Right to File a Complaint: You have the right to a paper copy of this notice. Please contact the SHBP Member Services Center at 1-800-610-1863 or you may download a copy at www.shbp.georgia.gov. 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.
MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OPT-OUT NOTICE

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

Date: July 25, 2017

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

Group health plans sponsored by state and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy. Your Plan Option is self-funded because the Department of Community Health (DCH) pays all claims directly instead of buying a health insurance policy. The Department of Community Health has elected to exempt your State Health Benefit Plan from the Mental Health Parity and Addiction Equity Act, that includes protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the Plan. The exemption from these federal requirements will be in effect for the plan year starting January 1, 2018 and ending December 31, 2018. The election may be renewed for subsequent plan years.

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

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Department of Community Health has determined that the Prescription Drug coverage offered under SHBP is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is, therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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<th>IF 65 OR OLDER WITH MEDICARE</th>
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<tr>
<td>If 65 or older with Medicare</td>
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<td>• Stop paying Part B and/or</td>
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<td>• Enroll in a non-State Health Benefit Plan (SHBP) MA Plan or Stand-Alone Part D Prescription Drug Plan</td>
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<td>• Do not have a physical address on file</td>
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<td>Then: Your Medicare Advantage with Prescription Drugs (MAPD) coverage under SHBP will be terminated and SHBP will move you to the Blue Cross and Blue Shield Bronze Health Reimbursement Arrangement (HRA) option and you will pay 100% of the unsubsidized premium.</td>
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<td>Note: Enrolling in a Medicare Supplemental Plan, such as Medigap, does not work with MAPD Plans. Medigap plans cannot be used to pay MAPD co-pays, co-insurance and/or premiums. You do not need to have both a Medigap and MAPD Plan.</td>
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<td>Without Medicare Part B</td>
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**Important Notice from State Health Benefit Plan (SHBP)**

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

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

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

**For More Information about Your Options Under Medicare Prescription Drug Coverage**

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

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

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

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

**From:** January 1, 2018 **To:** December 31, 2018  
**Date:** July 25, 2017

**Summaries of Benefits and Coverage**

Summaries of benefits and coverage describe each Plan Option in the standard format required by the Affordable Care Act. These documents are posted here: [www.shbp.georgia.gov](http://www.shbp.georgia.gov). To request a paper copy, you may call the SHBP Member Services Center 1-800-610-1863.

**Georgia Law Section 33-30-13 Notice:**

For 2018, some members will experience premium increases. Since some members will experience a premium increase, DCH provides the following notice: “SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is 0% higher than it would be if the Affordable Care Act provisions did not apply.”