

THE PPO/PPO CONSUMER CHOICE HEALTH BENEFITS PLAN



“Creating A More Educated Georgia”

THE UNIVERSITY SYSTEM OF GEORGIA

Plan Design – Effective January 1, 2009
Booklet Revised –January 2009

RESOURCE CONTACTS

Should you have questions regarding your PPO or your PPO Consumer Choice healthcare plan benefits, please contact the appropriate resource(s) identified below:

For Questions About:	Please Contact	Location
<p style="text-align: center;">Claims/Coverage Provided by the Plan</p> <p>For information regarding the participating providers.</p>	<p>Campus Human Resources/ Personnel Office</p> <p>Blue Cross Blue Shield of Georgia</p>	<p>Your Institution</p> <p>1-800-424-8950 TDD/404-842-8073</p>
<p style="text-align: center;">BCBSGa Online Tools and Online Provider Directory</p>	<p>Blue Cross Blue Shield of Georgia</p>	<p>www.bcbsga.com or www.bcbsga.com/bor</p>
<p style="text-align: center;">Pre-certification for Specific Outpatient/All Inpatient Hospital Services</p>	<p>Blue Cross Blue Shield of Georgia</p>	<p>1-800-233-5765 TDD/1-800-368-4424</p>
<p style="text-align: center;">24/7 NurseLine</p> <p>For emergency room referral and for medical information from a registered nurse, 24-hours a day, seven days a week.</p>	<p>Blue Cross Blue Shield of Georgia</p>	<p>1-800-785-0006 TDD/1-800-368-4424</p>
<p style="text-align: center;">360° Health Program</p>	<p>Blue Cross Blue Shield of Georgia</p>	<p>1-800-785-0006 TDD/1-800-368-4424</p>
<p style="text-align: center;">Centers of Excellence Transplant Program</p>	<p>Blue Cross Blue Shield of Georgia</p>	<p>1-866-694-0724 TDD/1-800-368-4424</p>
<p style="text-align: center;">Behavioral Health & Substance Abuse Providers/Facilities</p> <p>For information regarding the status, availability, and/or nomination of network providers/facilities, or, for obtaining pre-certification for benefits coverage.</p>	<p>Blue Cross Blue Shield of Georgia</p>	<p>1-800-292-2879 TDD/404-842-8073</p>
<p style="text-align: center;">Pharmacy Benefit Program</p>	<p>Medco</p>	<p>1-877-300-5139 TDD/1-800-759-1089</p>
<p style="text-align: center;">HIPAA Coverage</p>	<p>Secretary</p>	<p>U.S. Dept. of Health and Human Services Office of Civil Rights, Region IV 61 Forsyth St. SW, Suite 3B70 Atlanta, GA 30303-8909 404-562-7886 (metro Atlanta) 1-866-627-7748 (outside of metro Atlanta)</p>

University System of Georgia health benefits website: www.usg.edu/employment/benefits/health/

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**BOR Preferred Provider Organization (PPO) and PPO Consumer Choice Health
Benefits Plan Summary Document**

**YOUR PPO/PPO CONSUMER CHOICE
HEALTH BENEFITS PLAN**

INTRODUCTION

This booklet describes the Board of Regents PPO/PPO Consumer Choice Health Benefits Plan (the plan), available to employees and retirees of the University System of Georgia (the System), effective January 1, 2009.

Your health benefits plan is designed with two important goals in mind. The primary purpose of the healthcare plan is to provide you and your family with access to medical care in the event of an illness or serious injury. Your PPO/PPO Consumer Choice healthcare plan will offset member costs for medically necessary treatment of covered illnesses and/or injuries.

The second goal of the health benefits plan is to encourage covered members and their families to take an active role in decisions regarding their healthcare. That involvement begins with reading this booklet and with learning how the PPO/PPO Consumer Choice healthcare plan works. It is your responsibility to make efficient use of the coverage provided by the plan. Should you have questions regarding your benefits, as presented in this booklet, please contact your campus Human Resources/Personnel Office, or, the appropriate vendor. Vendors are listed on the inside front cover of this plan summary document.

BENEFITS AT A GLANCE

Provided for your information is a summary of selected benefits that are available to you and your family under the plan:

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<u>Maximum Lifetime Benefits</u> <i>(Medical & Pharmacy Benefits Combined)</i>	\$2 Million Combined In & Out-of-Network Benefits		
<u>Maximum Annual Deductible</u> <ul style="list-style-type: none"> • Individual • Family 	\$300 \$900	\$ 400 \$1,200	
<p>Members who use both Georgia Network providers and Out-of-Network providers will be responsible for two separate deductibles and for two separate, maximum out-of-pocket limits (stop loss).</p> <p>Members who use both National Network providers and Out-of-Network providers will be responsible for a combined maximum deductible of \$400/individual or \$1,200/family; and, for a combined maximum out-of-pocket limit (stop loss) of \$2,000/individual and \$4,000/family.</p> <p>Annual deductibles, annual maximum out-of-pocket limits (stop loss), and annual visit limitations, will be based on a January 1 - December 31 plan year.</p>			
<u>Maximum Annual Out-of-Pocket Limit (Stop Loss)</u> <ul style="list-style-type: none"> • Individual • Family 	\$1,000 \$2,000	\$2,000 \$4,000	
<p>Member co-payments for physician office visits, for emergency room services, and/or for prescription drugs do not apply toward the annual deductible(s) or toward the maximum annual out-of-pocket (stop loss) limit(s).</p> <p>Member costs incurred for balance billing will not apply toward the annual deductible(s) or toward the maximum annual out-of-pocket (stop loss) limit(s).</p>			

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<u><i>Pre-Existing Conditions</i></u>	None		
<u><i>Physician Services Provided In An Office Setting</i></u> <ul style="list-style-type: none"> • Physician Office Visit <p><i>For treatment of illness or injury</i></p>	<p>100% of network rate after \$20 co-payment per visit; <i>applies to non-surgical services; not subject to deductible.</i></p> <p>The \$20 co-payment applies to the physician's office visit <i>only</i>.</p> <p>The \$20 co-payment does not apply to covered charges associated with medical treatment/services. (Medical treatment/services may include services such as X-rays, laboratory tests, and/or diagnostic tests.)</p>	<p>100% of network rate after \$20 co-payment per visit; <i>applies to non-surgical services; not subject to deductible.</i></p> <p>The \$20 co-payment applies to the physician's office visit <i>only</i>.</p> <p>The \$20 co-payment does not apply to covered charges associated with medical treatment/services. (Medical treatment/services may include services such as X-rays, laboratory tests, and/or diagnostic tests.)</p>	<p>60% of eligible charges for <i>non-surgical</i> services; subject to deductible and balance billing.</p>
<ul style="list-style-type: none"> • Wellness Care/Preventive Healthcare <p><i>Physical Exam, Mammogram, Pap Smear, Prostate Exam/PSA, Well-baby Care and Immunizations, Adult Immunizations, Routine Eye Exams, Routine Hearing Exams</i></p>	<p>\$750 per person per plan year; paid at 100% of network rate; not subject to deductible. \$20 co-payment per office visit.</p> <p>The maximum wellness benefit that a covered member may receive when using Georgia and/or National In-Network providers is \$750 per person per plan year.</p>	<p>\$750 per person per plan year; paid at 100% of network rate; not subject to deductible. \$20 co-payment per office visit.</p> <p>The maximum wellness benefit that a covered member may receive when using Georgia and/or National In-Network providers is \$750 per person per plan year.</p>	<p style="text-align: center;">Not Covered</p> <p><i>Non-covered charges do not apply to annual deductible or annual out-of-pocket maximum.</i></p>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<ul style="list-style-type: none"> Laboratory Services <i>(Exclusive of Wellness Care/Preventive Healthcare)</i> <i>Laboratory, X-ray, Allergy Testing, Diagnostic Tests, and Injectable Medications.</i> <i>Injectable medications that are provided in a physician's office may be covered under medical benefits.</i> <i>Pre-certification for diagnostic testing may be required.</i> 	90% of network rate; <i>subject to deductible.</i>	80% of network rate; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> Maternity Care <i>(Routine Prenatal care, Delivery and Postnatal)</i> 	90% of network rate after an initial visit co-payment of \$20; <i>not subject to deductible.</i> There will be no co-payments charged for subsequent visits.	80% of network rate after an initial visit co-payment of \$20; <i>not subject to deductible.</i> There will be no co-payments charged for subsequent visits.	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> Outpatient Surgery <i>Pre-certification may be required.</i> 	90% of network rate; <i>subject to deductible.</i>	80% of network rate; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> Second Surgical Opinion <i>(Elective Surgery)</i> 	100% of network rate after a \$20 co-payment per visit; <i>not subject to deductible.</i>	100% of network rate after a \$20 co-payment per visit; <i>not subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> Allergy Testing 	90% of network rate; <i>subject to</i>	80% of network rate; <i>subject to</i>	60% of eligible charges; <i>subject</i>

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	<i>deductible.</i>	<i>deductible.</i>	<i>to deductible and balance billing.</i>
<ul style="list-style-type: none"> • Allergy Shots & Serum 	100% for allergy shots & serum; <i>not subject to deductible.</i> If a physician is seen, the visit is treated as an office visit and is subject to a \$20 co-payment per visit.	100% for allergy shots & serum; <i>not subject to deductible.</i> If a physician is seen, the visit is treated as an office visit and is subject to a \$20 co-payment per visit.	60% of eligible charges rate; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> • Treatment of TMJ (<i>Temporomandibular Joint Disorders</i>) <i>For diagnostic testing & non-surgical treatment</i> <i>Pre-certification may be required.</i> 	90% of network rate; <i>subject to deductible.</i> Lifetime benefit limit of \$1,100.	80% of network rate; <i>subject to deductible.</i> Lifetime benefit limit of \$1,100.	60% of eligible charges; <i>subject to deductible and balance billing.</i> Lifetime benefit limit of \$1,100.

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<p><u>Inpatient Hospital Services</u></p> <ul style="list-style-type: none"> • <u>Physician Services</u> <u>Physician Care/Surgery</u> <p><i>Physician services may include surgery, anesthesiology, pathology, radiology and/or maternity care/delivery.</i></p> <p><i>Pre-certification may be required.</i></p>	<p>90% of network rate; <i>subject to deductible.</i></p> <p>Some <i>hospital-based</i> physicians (examples: emergency room physicians, anesthesiologists, pathologists, and/or radiologists) providing services may not be a part of the network. Services provided by <i>non-network</i> physicians will be covered at 60% of the network rate; <i>subject to the out-of-network deductible and balance billing.</i></p>	<p>80% of network rate; <i>subject to deductible.</i></p> <p>Some <i>hospital-based</i> physicians (examples: emergency room physicians, anesthesiologists, pathologists, and/or radiologists) providing services may not be a part of the network. Services provided by <i>non-network</i> physicians will be covered at 60% of the network rate; <i>subject to the out-of-network deductible and balance billing.</i></p>	<p>60% of eligible charges; <i>subject to deductible and balance billing.</i></p>
<ul style="list-style-type: none"> • <u>Hospital Services Other Than Those For Emergency Room Care</u> <p><i>Inpatient Care (Includes inpatient short term rehabilitation services)</i></p> <p><i>Pre-certification may be required.</i></p>	<p>90% of contracted network rate; limited to semi-private room; <i>subject to deductible; not subject to balance billing.</i></p>	<p>80% of network rate; limited to semi-private room; <i>subject to deductible; not subject to balance billing.</i></p>	<p>60% of eligible charges; <i>subject to deductible and balance billing.</i></p>

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<ul style="list-style-type: none"> • <u>Maternity Care</u> (Delivery) 	90% of contracted network rate; <i>subject to deductible.</i>	80% of network rate; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> • <u>Laboratory Services</u> <i>X-ray, Laboratory Work, Diagnostic Testing. Provided in conjunction with treatment of an illness or injury.</i> <i>Pre-certification for diagnostic may be required.</i> 	90% of network rate; <i>subject to deductible.</i>	80% of network rate; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> • <u>Hospice Care</u> <i>Pre-certification is required.</i> 	100% of network rate; <i>subject to deductible.</i>	100% of network rate; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> • Treatment of TMJ (Temporomandibular Joint Disorders) <i>Surgical treatment</i> <i>Pre-certification may be required.</i> 	90% of network rate; <i>subject to deductible.</i>	80% of network rate; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<p><u>Outpatient Hospital/Facility Services</u></p> <ul style="list-style-type: none"> Physician Services Physician Care/Surgery <p><i>Physician services may include surgery, anesthesiology, pathology, radiology, and/or maternity care.</i></p> <p><i>Pre-certification may be required.</i></p>	<p>90% of network rate; <i>subject to deductible.</i></p> <p>Some <i>hospital-based</i> physicians (examples: emergency room physicians, anesthesiologists, pathologists, and/or radiologists) providing services may not be a part of the network. Services provided by <i>non-network</i> physicians will be covered at 60% of the network rate; <i>subject to the out-of-network deductible and balance billing.</i></p>	<p>80% of network rate; <i>subject to deductible.</i></p> <p>Some <i>hospital-based</i> physicians (examples: emergency room physicians, anesthesiologists, pathologists, and/or radiologists) providing services may not be a part of the network. Services provided by <i>non-network</i> physicians will be covered at 60% of the network rate; <i>subject to the out-of-network deductible and balance billing.</i></p>	<p>60% of eligible charges; <i>subject to deductible and balance billing.</i></p>
<ul style="list-style-type: none"> Facility Selected by a Treating Physician <p><i>Treatment/care provided in an outpatient setting may require pre-certification.</i></p>	<p>90% of network rate; <i>subject to deductible.</i></p> <p>Some <i>facilities</i> selected by a treating physician may not be a part of the network. Services provided at <i>non-network facilities</i> will be covered at 60% of network rate; <i>subject to out-of-network deductible and balance billing.</i></p>	<p>80% of network rate; <i>subject to deductible.</i></p> <p>Some <i>facilities</i> selected by a treating physician may not be a part of the network. Services provided at <i>non-network facilities</i> will be covered at 60% of network rate; <i>subject to out-of-network deductible and balance billing.</i></p>	<p>60% of eligible charges; <i>subject to deductible and balance billing.</i></p>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<ul style="list-style-type: none"> Care in a Hospital Emergency Room (ER) <i>For treatment of an emergency medical condition or injury</i> 	90% of network rate after a \$75 co-payment per visit; <i>subject to deductible.</i> Co-payment is reduced to \$50 if referred by <i>24/7 NurseLine</i> . Co-payment is waived if admitted within 24 hours.	90% of network rate after a \$75 co-payment per visit; <i>subject to the in-network deductible.</i> Co-payment is reduced to \$50 if referred by <i>24/7 NurseLine</i> . Co-payment is waived if admitted within 24 hours.	90% of eligible charges after a \$75 co-payment per visit; <i>subject to the in-network deductible; subject to balance billing.</i> Co-payment is reduced to \$50 if referred by <i>24/7 NurseLine</i> . Co-payment is waived if admitted within 24 hours.
<ul style="list-style-type: none"> Laboratory Services <i>X-ray, Laboratory Work, Diagnostic Testing. Provided in conjunction with treatment of an illness or injury.</i> <i>Pre-certification for diagnostic testing may be required.</i> 	90% of network rate; <i>subject to deductible.</i>	80% of network rate; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> Urgent Care Services 	90% of network rate after a \$20 co-payment per visit; <i>subject to deductible.</i>	80% of network rate after a \$20 co-payment per visit; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> Home Hyperalimentation <i>Pre-certification may be required.</i> 	90% of network rate; <i>subject to deductible.</i> Lifetime benefit limit of \$500,000.	80% of network rate; <i>subject to deductible.</i> Lifetime benefit limit of \$500,000.	60% of eligible charges; <i>subject to deductible and balance billing.</i> Lifetime benefit limit of \$500,000.
<ul style="list-style-type: none"> Home Nursing Care 	90% of network rate; limited to	80% of network rate; limited to	60% of eligible charges; limited

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<i>Pre-certification may be required.</i>	(two) 2 hours of care in a 24-hour day; <i>subject to deductible.</i> In lieu of hospitalization and with prior approval, additional benefits may be allowed. Charges <i>do NOT</i> apply to annual out-of-pocket maximum. Limited to \$7,500 per person per plan year; <i>plan approved Letter of Medical Necessity required.</i>	(two) 2 hours of care in a 24-hour day; <i>subject to deductible.</i> In lieu of hospitalization and with prior approval, additional benefits may be allowed. Charges <i>do NOT</i> apply to annual out-of-pocket maximum. Limited to \$7,500 per person per plan year; <i>plan approved Letter of Medical Necessity required.</i>	to (two) 2 hours of care in a 24-hour day; <i>subject to deductible and balance billing.</i> In lieu of hospitalization and with prior approval, additional benefits may be allowed. Charges <i>do NOT</i> apply to annual out-of-pocket maximum. Limited to \$7,500 per person per plan year; <i>plan approved Letter of Medical Necessity required.</i>
<ul style="list-style-type: none"> Hospice Care <i>Pre-certification may be required.</i>	100% of network rate; <i>subject to deductible.</i> In lieu of hospitalization and with prior approval, additional benefits may be allowed.	100% of network rate; <i>subject to deductible.</i> In lieu of hospitalization and with prior approval, additional benefits may be allowed.	60% of eligible charges; <i>subject to deductible and balance billing.</i> In lieu of hospitalization and with prior approval, additional benefits may be allowed.
<ul style="list-style-type: none"> Cochlear Implants <i>Pre-certification is required.</i>	90% of network rate; <i>subject to deductible.</i>	90% of network rate; <i>subject to deductible.</i>	60% of eligible charges; <i>subject to deductible and balance billing.</i>

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<ul style="list-style-type: none"> Ambulance Services <i>Land or air ambulance for medically necessary emergency transportation only</i> 	90% of network rate; <i>subject to deductible; subject to balance billing for non-participating providers of ambulance services.</i>	90% of network rate; <i>subject to the in-network deductible. Subject to balance billing for non-participating providers of ambulance.</i>	90% of eligible charges; <i>subject to the in-network deductible and balance billing.</i>
<ul style="list-style-type: none"> Durable Medical Equipment (DME) <i>Rental or Purchase</i> <i>Plan may require approved Letter of Medical Necessity and Pre-certification may be required.</i> 	90% of network rate; <i>subject to deductible.</i>	80% of network rate; <i>subject to deductible.</i>	60% of network rate; <i>subject to deductible and balance billing.</i>
<ul style="list-style-type: none"> Outpatient Short Term Rehabilitation Services <i>Pre-certification may be required.</i> 	90% of network rate; <i>subject to deductible.</i> Physical, speech, cardiac and occupational therapies are limited to 40 visits per incident type per plan year.	80% of network rate; <i>subject to deductible.</i> Physical, speech, cardiac and occupational therapies are limited to 40 visits per incident type per plan year.	60% of eligible charges; <i>subject to deductible and balance billing.</i> Physical, speech, cardiac and occupational therapies are limited to 40 visits per incident type per plan year.
<ul style="list-style-type: none"> Chiropractic Care 	90% of network rate; <i>subject to deductible.</i> Limited to 40 visits per member per plan year.	80% of network rate; <i>subject to deductible.</i> Limited to 40 visits per member per plan year.	60% of eligible charges; <i>subject to deductible and balance billing.</i> Limited to 40 visits per member per plan year.
<u>Limited Medical Coverage for</u>	90% of network rate; <i>subject to</i>	80% of network rate; <i>subject to</i>	60% of eligible charges; <i>subject</i>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<p><u>Dental/Oral Care</u></p> <ul style="list-style-type: none"> Surgical Extraction of Impacted Teeth <p><i>Medical benefits are not available for partially erupted teeth.</i></p>	<p><i>deductible.</i></p>	<p><i>deductible.</i></p>	<p><i>to deductible and balance billing.</i></p>
<ul style="list-style-type: none"> Dental/Oral Care <p><i>Not covered; other than accidental injury to natural teeth.(initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily injury to sound natural teeth or structure occurring while a member is covered by this contract and performed within 180 days after the accident.)</i></p> <p><i>Please Note: Outpatient charges and anesthesia for dental services for children may be covered but will require prior approval.</i></p>	<p>90% of network rate; <i>subject to deductible; subject to balance billing if services are not rendered by a network provider.</i></p> <p><i>Network providers may not be available for all covered services.</i></p>	<p>80% of network rate; <i>subject to deductible; subject to balance billing if services are not rendered by a network provider.</i></p> <p><i>Network providers may not be available for all covered services.</i></p>	<p>60% of eligible charges; <i>subject to deductible and balance billing.</i></p>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<p><u><i>Pharmacy Benefit Manager</i></u></p> <p><i>Vendor: Medco</i></p>	<p align="center"><i>3-Tier Co-payment Structure For Up To a 30-Day Supply</i></p> <p align="center"><i>Generic:</i> \$10 member co-payment <i>Preferred Brand Name:</i> \$25 member co-payment <i>Non-Preferred Brand Name:</i> 20% co-payment of non-preferred brand name drug cost; with minimum member co-payment of \$40/maximum member co-payment of \$100.</p> <ul style="list-style-type: none"> • If the usual and customary charge for a generic or preferred brand name drug is less than the payment amount, the member will pay the lesser of the two. • If a physician indicates “Brand Necessary” on a prescription, then only a preferred or nonpreferred brand name medication can be dispensed. The member will be responsible for the preferred/nonpreferred brand name medication copayment. • If a physician does not indicate “Brand Necessary” and the member chooses a preferred/nonpreferred brand name medication over its available generic equivalent, the member will be required to pay the generic copayment. • In addition to paying the generic copayment, the member will also be responsible for paying the difference in the cost between the generic and the preferred/nonpreferred brand name drug. This difference in member cost is sometimes referred to as an “ancillary charge.” <p><i>Days Supply</i> One co-payment for up to a 30-day supply. Maintenance Medications Maintenance medications are those prescription drugs that a member may obtain for a period of up to 90 days. The member will be charged one copayment for each supply of medication up to a 30-day supply.</p> <p><i>Other Coverage Rules</i></p>		

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>								
	<p>For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/ tablets of medication per prescription.</p> <p style="text-align: center;"><i>Quarterly Out-of-Pocket Maximums for Use of Generic and Preferred Brand Medications</i></p> <table data-bbox="793 597 1684 743"> <tr> <td>Employee</td> <td style="text-align: right;">\$ 450 per quarter</td> </tr> <tr> <td>Employee + Child (Two (2) covered members)</td> <td style="text-align: right;">\$ 900 per quarter</td> </tr> <tr> <td>Employee + Spouse (Two (2) covered members)</td> <td style="text-align: right;">\$ 900 per quarter</td> </tr> <tr> <td>Family (Three (3) or more covered members)</td> <td style="text-align: right;">\$1,350 per quarter</td> </tr> </table> <p>A quarter will consist of three consecutive months as designated below:</p> <p style="text-align: center;">1st Quarter - January through March 2nd Quarter - April through June 3rd Quarter - July through September 4th Quarter - October through December</p>			Employee	\$ 450 per quarter	Employee + Child (Two (2) covered members)	\$ 900 per quarter	Employee + Spouse (Two (2) covered members)	\$ 900 per quarter	Family (Three (3) or more covered members)	\$1,350 per quarter
Employee	\$ 450 per quarter										
Employee + Child (Two (2) covered members)	\$ 900 per quarter										
Employee + Spouse (Two (2) covered members)	\$ 900 per quarter										
Family (Three (3) or more covered members)	\$1,350 per quarter										

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<p><u>Mental Health and Substance Abuse</u></p> <p><i>Vendor: BCBSGa</i></p> <p><i>Please contact BCBSGa to determine if pre-certification is required at 1-800-292-2879.</i></p> <p><i>Failure to pre-certify, when required, will result in <u>reduced level of benefit coverage or no benefit coverage.</u></i></p> <p>Annual out-of-pocket maximum of \$2,500 per patient per plan year for referred network care.</p> <p>Annual out-of-pocket maximum applies to combined <i>inpatient</i> and <i>outpatient</i> services.</p>	<p style="text-align: center;"><u>Inpatient</u></p> <p>Facility Charges:</p> <ul style="list-style-type: none"> ▪ <u>In-network:</u> 90% of network rate; <i>subject to deductible <u>and</u> to a separate \$100 hospital deductible with vendor referral.</i> ▪ <u>Out-of-network:</u> 60% of network rate; <i>subject to deductible <u>and</u> to a separate \$100 hospital deductible with vendor referral. Balance billing may apply.</i> ▪ Maximum benefit of 60 combined mental health and substance abuse days per person per plan year. ▪ Inpatient substance abuse coverage limited to 3 episodes per lifetime. <p>Partial/Day Hospitalization & Intensive Outpatient Charges:</p> <ul style="list-style-type: none"> ▪ 90% of network rate; <i>subject to deductible <u>and</u> to a separate \$100 hospital deductible.</i> ▪ Maximum benefit of 30 combined visits/days of partial day/hospitalization and intensive outpatient treatment per person per plan year. ▪ <i>Benefit coverage is only available at in-network facilities.</i> 		<p style="text-align: center;">Not Applicable</p>
<p><u>Mental Health and Substance</u></p>	<p style="text-align: center;"><u>Inpatient</u></p>		<p style="text-align: center;">Not Applicable</p>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<u>Abuse</u>	<p>Provider Charges</p> <ul style="list-style-type: none"> ▪ <u>In-network</u>: 80% of network rate; with vendor referral and <i>subject to deductible</i>. Maximum of 60 visits per person per plan year. ▪ <u>Out-of-network</u>: 50% of network rate; with vendor referral and <i>subject to deductible and balance billing</i>. Maximum of 25 visits per person per plan year. ▪ <i>Benefit coverage is only available when using an in-network provider for Partial/Day Hospitalization & Intensive Outpatient Charges</i> <p style="text-align: center;"><u>Outpatient</u></p> <p>Provider Charges</p> <ul style="list-style-type: none"> ▪ <u>In-network</u>: 80% of network rate <i>with authorization; subject to deductible</i>. Maximum benefit coverage of 50 combined mental health, substance abuse, and brief-therapy visits per person per plan year. ▪ <u>Out-of-network</u>: 50% of eligible charges <i>without authorization; subject to deductible and to balance billing</i>. Maximum benefit coverage of 25 combined mental health, substance abuse, and brief-therapy visits per person per plan year. Plan coverage/benefits limited to services/treatments rendered by a Psychiatrist (MD) or a Psychologist (Ph.D.). ▪ Annual 50-visit limit includes in-network, out-of-network and three (3) brief therapy sessions. 		

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>Georgia In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>National In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<u>Mental Health and Substance Abuse</u>	<p align="center"><i>Brief-Therapy Annual Visit Limit</i></p> <ul style="list-style-type: none"> ▪ 100% of the network rate; not subject to deductible. ▪ Three of the 50 combined mental health and substance abuse visits may be used for brief-therapy consultations. ▪ <i>A network provider must pre-certify and conduct the brief-therapy session.</i> 		Not Applicable
<p><u>Organ and Tissue Transplants</u></p> <p><i>The Centers of Excellence Programs direct patients to network heart, liver, lung and bone marrow transplant specialists.</i></p> <p><i>Prior approval may be required.</i></p> <p><i>*The lifetime benefits limit of \$500,000 will also apply to the \$2,000,000 lifetime maximum.</i></p>	<p><i>In-Network:</i> 90% of vendor network rate at a contracted transplant center; <i>subject to in-network deductible and to separate \$100 hospital deductible.</i></p> <p>The lifetime benefit limit for expenses related to a <i>donor search</i>, when using a contracted transplant Center, is \$10,000.</p> <p><i>Out-of-Network:</i> 60% of UCR at a non-contracted transplant center; <i>subject to out-of-network deductible, to a separate \$100 hospital deductible, and to balance billing.</i></p> <p><i>There will be no donor search benefit provided if an individual uses a non-contracted transplant center.</i></p> <p>*Lifetime benefit limit of \$500,000 (Transplant phase and \$10,000 donor search benefit).</p> <p>For additional information regarding the COE Program for organ and tissue transplants, please contact BCBSGa at 1-866-694-0724.</p>		Not Applicable

OUT OF COUNTRY

Subject to the Georgia In-Network Deductible
Co-Insurance: 90% of Network Rate
Note: All plan exclusions and limitations still apply.

Subject to the Out-of-Network Deductible
Co-Insurance: 60% of eligible charges.
Note: All plan exclusions and limitations still apply.

WHO CAN ENROLL

If you are employed by the University System of Georgia for at least 20 hours per week on a regular basis, you are eligible for coverage under the PPO/PPO Consumer Choice healthcare plan beginning your first day at work. If you are a member of the Corps of Instruction (teaching faculty) under contract on at least a regular half-time basis, you are eligible for coverage beginning the first day of the month in which you are required to be at work.

HOW TO ENROLL

You must complete a PPO/PPO Consumer Choice health benefits plan enrollment form to apply for healthcare coverage. You may obtain this form from your campus Human Resources/Personnel Office. The completed enrollment form must include the legal names and birth dates of all eligible dependents.

The PPO/PPO Consumer Choice healthcare plans provide four levels of coverage:

Single	Employee + Child	Employee + Spouse	Family
Employee Only	Employee + One Dependent Child	Employee + Spouse	Employee + Two or More Dependents (Spouse and/or Children)

DEPENDENT COVERAGE

When an employee elects “*Employee + Child*”, “*Employee + Spouse*”, or “*Family*” coverage, his/her eligible dependents may be covered by the healthcare plan selected. Eligible dependents of an employee include:

- Legal spouse;
- Unmarried, natural and adopted children under age 19; or to age 26, if verification of full-time student status at an accredited school is provided;
- Children who have been placed for adoption in connection with assumption by the person of a legal obligation for the total or partial support of a child in anticipation of the legal adoption of such child.
- Unmarried step-children under age 19 who depend on the employee for support and maintenance and who live with the employee in a normal parent-child relationship; or to age 26, who depend on the employee for support and who can provide written verification of full-time student status at an accredited school;

- Unmarried children for whom, as a result of a legal separation or divorce, the employee is legally responsible, even though they may not live with the employee;
- Children for whom the covered employee is the *permanent* legal guardian if:
 - A court has named the employee as the child’s permanent guardian; *and*
 - The child lives in the employee’s home in a normal parent-child relationship; *and*
 - The child is dependent on the employee for support.
- Unmarried, disabled children beyond the age limit if:
 - They are unable to support themselves; *and*
 - They depend on the employee for support; *and*
 - The condition existed prior to age 19 (or age 26, if they become incapacitated while a full-time student); *and*
 - Proof of incapacity is furnished within 30 days of the child’s 19th birthday (or age 26, if they become incapacitated while a full-time student).

If you have a dependent(s) employed by the University System of Georgia, and your dependent(s) is participating in any University System of Georgia healthcare plan, you *may not* cover that dependent(s) under your “*employee + child*”, “*employee + spouse*”, or “*family*” coverage.

If your spouse is employed by the University System of Georgia, but he/she does not elect to participate in an available healthcare plan, you may cover him/her under your “*employee + spouse*” or “*family*” coverage.

If both a husband and wife are benefits-eligible employees of the University System of Georgia, only one may elect to provide coverage for the other spouse and/or dependents.

WHEN EMPLOYEE COVERAGE BEGINS

If you enroll in healthcare coverage on your first day of employment, you will be covered by the plan as of:

- Your employment date; or
- The first of the month following your date of employment.

As an employee of the University System of Georgia, you have 30 days from your effective date of employment to enroll for coverage in a healthcare plan. If you enroll in a healthcare plan within 30 days of your employment date, you will be covered by the plan as of:

- The date you enroll; or
- The first of the month following your date of employment.

You will have the opportunity to determine when you wish to have your coverage begin; but, in either instance, you will be required to pay for a full month of coverage. It is important that you enroll within 30 days of your date of employment. You will not be permitted to enroll in an available healthcare plan again until the next University System of Georgia open enrollment period.

Open enrollment is generally held during the fall of each calendar year. Healthcare plan elections made during an open enrollment period will become effective at the beginning of a new plan year. The plan year for the University System of Georgia is currently a calendar year (January 1 – December 31).

If you are absent from work, due to illness or injury, on the date that your healthcare plan coverage is to be effective, participation in the plan will begin on the first day that you return to active work. Active work is defined as performing all regular and assigned duties at one's normal or required work location.

WHEN DEPENDENT COVERAGE BEGINS

An eligible dependent will become covered on:

- The first day that he/she becomes eligible; or
- The first of the month following his/her date of eligibility.

You will be required to ensure that your dependents, including newborns, are enrolled under your plan coverage within 30 days following his/her eligibility date. You should contact your campus Human Resources/Personnel Office to convey all appropriate information.

An eligible newborn is covered at birth. A dependent, other than a newborn, who is confined to a hospital or other institution when his/her coverage would normally begin, will be covered upon his/her discharge.

If you enroll your dependents within 30 days following their eligibility date, their coverage will begin on:

- The date you apply for coverage; or
- The first of the month following the date in which you apply for coverage.

You will have the opportunity to determine when you wish to have your dependent's coverage begin; but, in either instance, you will be required to pay for a full month of coverage. It is important that you enroll your dependents within 30 days of their becoming eligible for coverage. You will not be permitted to enroll your dependents in an available healthcare plan again until the next University System of Georgia open enrollment period.

ADDING OR DELETING DEPENDENTS

When you have a qualifying event, you will need to contact your campus Human Resources/Personnel Office to complete a change form to add or to delete a dependent. Some examples of "*qualifying events*" include: (A) a change in employment status for you or your spouse; (B) a change in marital status; and (C) the birth or adoption of a child (including stepchildren and legally placed foster children). *There are other examples of qualifying events.*

Change forms must be completed with your campus Human Resources/Personnel Office within 30 days of a qualifying event. Failure to comply with this time requirement will prohibit you from changing your coverage until the next University System of Georgia open enrollment period.

Full-Time Student Verification Process for Dependents Between the Ages 19-25

Ninety (90) days prior to a dependent reaching his/her nineteenth (19) birthday, Blue Cross Blue Shield of Georgia will mail a letter to the contract holder requesting that he/she provide verification of his/her dependent's full-time student status.

The contract holder will be required to submit documentation of full-time student status to the institutional Human Resources/Personnel Office where he/she is employed. Examples of required documentation include a *student registration schedule*, a *student enrollment tuition receipt*, or a *student enrollment confirmation letter from the dependent's school*. To ensure continuous coverage, the contract holder must provide the required documentation to his/her employing institution, prior to his/her dependent attaining age 19.

Upon receipt of the required documentation, the employing institution will make the necessary adjustments to the dependent's healthcare coverage. *Should a contract holder fail to provide the requisite documentation to his/her employing institution, coverage for the student dependent will be terminated.* It will be the contact holder's responsibility to notify his/her campus Human Resources/Personnel Office when the member, or his/her covered dependent(s), are no longer eligible for University System of Georgia healthcare coverage. Such notification is required for the member and his/her covered dependent(s) to be eligible to participate in COBRA healthcare coverage.

Each year ninety days prior to the dependent's birthday, BCBSGa will mail the contract holder an annual letter requiring verification of full-time student status for his/her dependents that are between the ages of 19 and 25.

Change of Full-Time Student Status Upon Attainment of Age 26

Your PPO/PPO Consumer Choice healthcare plan will provide coverage for your full-time student dependent until he/she attains age 26. *On a dependent's 26th birthday*, his/her healthcare coverage will terminate. For information regarding your dependent's ability to continue healthcare coverage, please see page 73 for the section entitled, *Your COBRA Rights*.

USG OPEN ENROLLMENT PERIOD

Open enrollment is generally held during the fall of each calendar year. A University System of Georgia open enrollment period covers a 30 calendar-day time frame. Your Human Resources/Personnel Office will advise you of the specific dates for your campus open enrollment period.

Healthcare plan elections made during an open enrollment period will become effective at the beginning of a new plan year. The plan year for the University System of Georgia is currently a calendar year (January 1 – December 31).

During an open enrollment period, an active and eligible employee may elect to: (1) enroll in a healthcare plan; (2) drop healthcare coverage; (3) participate in a different healthcare plan option; and/or (4) change his/her level of coverage (i.e. single, employee + child, employee + spouse, or family). Members who have COBRA coverage will have the same open enrollment period and options.

THE COST OF YOUR HEALTHCARE COVERAGE

The University System of Georgia contributes a majority of the cost associated with your health benefits plan coverage. Information regarding employer/employee healthcare plan contribution rates is shared with your campus Human Resources/Personnel Office. The costs associated with providing various healthcare plan options to employees, retirees and dependents of the University System of Georgia changes periodically. Your campus Human Resources/Personnel Office will notify you of any changes in plan costs and in employer/employee contribution rates. Your premium will depend upon the level of coverage (single, employee + child, employee + spouse, or family) that you select. The healthcare plan premium contribution for active, eligible employees will be paid with *pre-tax* dollars.

QUALIFYING EVENTS FOR CHANGES IN HEALTHCARE PLAN COVERAGE

Because your share of the cost for healthcare plan premiums is paid with *pre-tax* dollars, the Internal Revenue Services (IRS) has established strict rules regarding the operation of your healthcare plan. IRS rules state that the choices made by a covered member during an annual open enrollment period must remain in effect for the entire plan year (January 1 through December 31). The only exception permitted under IRS rules is when a covered member has a *qualifying event*.

If you have a qualifying event, you may add, change, or discontinue healthcare coverage. Appropriate documentation, specific to the qualifying event, must be presented to your campus Human Resources/Personnel Office *before* a change in healthcare plan coverage will be granted or approved. Some examples of qualifying events include:

- A change in your marital status;
- The birth or adoption of a child (including stepchildren and legally placed foster children);

- The death of a covered dependent;
- A change in the employment status of a covered member, his/her spouse, or his/her covered dependent(s), that affects eligibility for coverage under a cafeteria or other qualified healthcare plan;
- The loss of eligibility status by a covered dependent;
- A campus approved leave of absence without pay (maximum of 12 months);
- You and/or your spouse being called to full-time active military service/duty;
- Losing or gaining healthcare coverage eligibility under Medicare or Medicaid;
- A change in residence to a location outside of a healthcare plan's service area;
- Healthcare plan election choices made by spouses with different employers in which the employers have a different healthcare plan years (*Please see the example below*); or

Example:

You work for the University System of Georgia (USG) and have a January 1 – December 31 health benefits plan year. Your spouse works for XYZ employer. XYZ has an October 1 – September 30 health benefits plan year. ***Both employer health benefits plans are qualified healthcare plans.***

You have “*single*” healthcare coverage with the University System of Georgia. Your spouse, employed by XYZ, discontinues his/her healthcare coverage with XYZ effective September 30. September 30 is the end of employer XYZ's plan year. You wish to add your spouse, employed by XYZ, under your healthcare plan with the University System of Georgia, effective October 1. You request to make this change to avoid a break in healthcare coverage for your spouse.

Your spouse, employed by XYZ, conveys to XYZ that he/she will no longer participate in XYZ's healthcare plan effective October 1. Under IRS regulations, the University System of Georgia may permit you to change your election from “*single*” to “*employee + spouse*” effective October 1. The spouse, employed by XYZ, must provide documentation/certification to the USG that he/she has lost healthcare coverage with XYZ.

Qualified Medical Child Support Order (QMCSO)

A court-ordered qualified medical child support order (QMCSO) results from a divorce, legal separation, annulment, or change in legal custody. A QMCSO will require that you, your spouse, former spouse or other individual provide healthcare coverage for those enrolled dependent(s) that have been approved by the court. The court order and the effective date of healthcare plan coverage for those court-designated enrolled dependent(s) must be presented to your Human Resources/Personnel Office within 90 days of the court's decision.

PLEASE NOTE:

For each of the qualifying events identified above, you must file a *timely* request with your Human Resources/Personnel Office to add or to change healthcare coverage. For instances other than a qualified medical child support order (QMCSO), "*timely*" means *within 30 days of the event* that qualified you for a change in healthcare coverage (i.e., employment, loss of coverage, marriage, birth or adoption, etc.) A QMCSO must be presented to your Human Resources/Personnel Office within 90 days of a court's decision.

A failure to complete a change form within 30 days of a qualifying event will prohibit you from making such changes until the next University System open enrollment period. Unless otherwise noted, the effective date for changes in healthcare coverage will be the first day of the month following institutional approval.

CONTINUATION OF HEALTHCARE COVERAGE INTO RETIREMENT

A University System of Georgia retiree, who, upon his/her separation from employment with the University System of Georgia, meets the criteria for retirement as set forth in Section 802.0902 (Definition of a Retiree/Eligibility for Retirement) of *The Policy Manual*, shall remain eligible to continue as a member of one of the System's group health benefits plans. The level of healthcare coverage that one may take into retirement will be the level of coverage that he/she had immediately prior to retirement.

USG RETIREE ANNUAL CHANGE PERIOD

The USG retiree annual change period is generally held during the fall of each calendar year. The USG retiree annual change period will coincide with the same 30 calendar-day time frame designated as the USG open enrollment period for active, eligible employees. The institutional Human Resources/Personnel Office, from which an individual retires, will advise the retiree of the specific dates for his/her annual change period.

A retiree will not be permitted to participate in the annual change period unless he/she elected to take healthcare coverage into retirement at the time of his/her separation from employment with the University System of Georgia.

During an annual retiree change period, an eligible retired employee may elect to: (1) drop or discontinue healthcare coverage; (2) participate in a different healthcare plan option; and/or (3) reduce his/her level of coverage. During the annual change period, a retiree shall not be permitted to add healthcare coverage, or, increase the level of coverage that he/she took into retirement, *unless it is the result of one of four (4) qualifying events*.

Following institutional approval, any change in retiree healthcare coverage will become effective within 30 days of the qualifying event; *not at the beginning of the next plan year*.

QUALIFYING EVENTS FOR CHANGES IN RETIREE HEALTHCARE PLAN COVERAGE

A USG retiree will be permitted to make a change in the level of healthcare coverage that he/she took into retirement, if he/she has a *qualifying event*. The change in retiree healthcare coverage must be consistent with the *qualifying event*. A retiree will be required to provide the proper documentation to justify a requested benefits coverage change to the institutional Human Resources/Personnel Office from which he/she retired. A retiree must request a coverage change within 30 days of the *qualifying event*.

Appropriate documentation, specific to the qualifying event, must be presented to your campus Human Resources/Personnel Office *before* a change in healthcare plan coverage will be granted or approved.

There will be only four (4) instances of a *qualifying event* that a University System of Georgia institution may consider in granting a change in the level of healthcare coverage for a USG retiree. They are:

- (1) Becoming eligible for Medicare;
- (2) The addition of a dependent(s) because of marriage, birth, adoption or a Qualified Medical Child Support Order (QMSCO);
- (3) The loss of a dependent's health benefit coverage through a change in a spouse's group coverage, through COBRA coverage, through Medicare, or through Medicaid; and
- (4) A change in a spouse's employment status that affects coverage eligibility under a qualified health plan.

A Qualified Medical Child Support Order (QMSCO) is a court-ordered remedy resulting from a divorce, legal separation, annulment, or change in legal custody. A QMSCO requires that an individual provide healthcare coverage for an enrolled dependent(s) that has been approved by the court. The court order and effective date of healthcare plan coverage for a court-designated enrolled dependent(s) must be presented to the institutional Human Resources/Personnel Office from which an individual retired, within 90 days of the court's decision.

PLEASE NOTE:

For each of the four (4) qualifying events that are identified above, one must file a *timely* request with the Human Resources/Personnel Office from which he/she retired. For instances other than a qualified medical child support order (QMCSO), “*timely*” means *within 30 days of the qualifying event*. A QMCSO must be presented to the appropriate Human Resources/Personnel Office within 90 days of the court’s decision.

A failure to complete a change form within 30 days of a qualifying event will prohibit one from making such changes. Unless otherwise noted, the effective date for changes in healthcare coverage will be the first day of the month following the institution’s approval.

PERMISSIBLE USG RETIREE HEALTHCARE PLAN CHANGES

Please be reminded that retiree healthcare premiums *are not paid with pre-tax dollars*. Therefore, a retiree may reduce his/her healthcare coverage, or, discontinue his/her healthcare coverage at any time during the plan year. If you wish to reduce your healthcare coverage, or, if you wish to discontinue your healthcare coverage, please submit your request in writing to the Human Resource/Personnel Office from which you retired.

Please be reminded that if you reduce your level of healthcare coverage, you *will not be permitted* to increase your coverage at a later date, without establishing one of the four (4) qualifying events previously identified. *As a retiree, if you elect to discontinue your healthcare coverage, you will not be permitted to re-enroll at a later date.*

THE ANNUAL DEDUCTIBLE

The annual deductible is an amount of money that you will be required to pay each plan year (January 1 – December 31) for covered benefit expenses, before the plan will begin to pay for its portion of covered charges. Your annual healthcare plan deductibles are as follows:

Maximum Annual Deductible	Plan Provisions and Benefits <i>Georgia In-Network</i>	Plan Provisions and Benefits <i>National In-Network</i>	Plan Provisions and Benefits <i>Out-of-Network</i>
Individual	\$300	\$400	
Family	\$900	\$1,200	

Members who use both Georgia Network providers *and* Out-of-Network providers will be responsible for **two separate deductibles**. Members who use both National Network providers *and* Out-of-Network providers will be responsible for a **combined maximum deductible**. The family deductible can be met through any combination of covered medical expenses incurred by two or more covered members within a household.

Member co-payments for physician office visits, emergency room services, urgent care services, and/or prescription drugs do not apply toward the annual deductible for the PPO/PPO Consumer Choice healthcare plan. Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).

THE MAXIMUM ANNUAL OUT-OF-POCKET LIMIT (Stop Loss)

The PPO/PPO Consumer Choice healthcare plan provides for a member’s protection if his/her out-of-pocket covered expenses reach a certain limit during a plan year.

For a member who uses a Georgia In-Network provider, the annual out-of-pocket limit is \$1,000 for individual coverage and \$2,000 for family coverage. For a member who: (1) uses a National In-Network PPO provider; or (2) uses an Out-of-Network provider; or (3) uses a combination of National In-Network providers *and* Out-of-Network providers; the annual out-of-pocket limit is \$2,000 for individual coverage and \$4,000 for family coverage.

Your PPO/PPO Consumer Choice maximum annual out-of-pocket limit (stop loss) will be:

Maximum Annual Out-of-Pocket (Stop Loss)	Plan Provisions and Benefits <i>Georgia In-Network</i>	Plan Provisions and Benefits <i>National In-Network</i>	Plan Provisions and Benefits <i>Out-of-Network</i>
Individual	\$1,000	\$2,000	\$2,000
Family	\$2,000	\$4,000	\$4,000

For a member who uses both a Georgia Network provider and an Out-of-Network provider, he/she will be responsible for **two separate stop loss limits**.

If your individual or family out-of-pocket covered expenses reach the *Georgia In-Network stop loss limit during the plan year*, the plan will pay 100% of your covered *Georgia In-Network expenses* for the remainder of the plan year.

If your individual or family out-of-pocket covered expenses reach the *National In-Network and/or the out-of-network stop loss limit during the plan year*, the plan will pay 100% of your covered *National In-Network and/or out-of-network expenses* for the remainder of the plan year.

Just as with the family annual deductible, the family maximum annual out-of-pocket limits can be met through any combination of covered medical expenses incurred by two or more covered members within a household. The family out-of-pocket limit can be met without each family member meeting a separate, individual out-of-pocket limit.

For mental health and substance abuse treatment, there is a separate annual maximum out-of-pocket limit of \$2,500 per person per plan year for referred network care. BCBSGa provides behavioral health and substance abuse services.

The maximum annual out-of-pocket limit includes any plan deductible or the member's portion that he/she is required to pay for medical benefits. The maximum annual out-of-pocket limit for medical benefits *excludes*:

- Expenses for medical services that are not covered by the PPO/PPO Consumer Choice healthcare plan (page 62);
- Expenses for medical services in which the member fails to comply with the Medical Utilization Review Program requirements (pages 39-41);
- Expenses for covered medical services that exceed the contracted network rate for out-of-network provider services (page 32);
- Expenses for medical services exceeding other plan limits;
- Expenses for incurred medical and pharmacy services that exceed the maximum lifetime benefit of \$2 million;
- Expenses for medical services that are not paid by the University System of Georgia PPO/PPO Consumer Choice plan because of a coordination of benefits (COB) with any other plan(s) that covers you and/or your dependents (page 70);
- Balance billing costs incurred by a member for his/her use of any out-of-network provider (page 32); and
- Member co-payments for physician office visits, emergency room services, urgent care services, and/or prescription drugs.

PLEASE NOTE:

Member co-payments for physician office visits, emergency room services, urgent care services, and/or prescription drugs do not apply toward the annual deductible or toward the maximum annual out-of-pocket limit (stop-loss).

Members who elect to use out-of-network medical providers will be subject to balance billing. Amounts that are balance billed by a provider are the member's responsibility. These charges do not apply toward the annual deductible or toward the maximum annual out-of-pocket limits for the PPO/PPO Consumer Choice healthcare plan.

MAXIMUM LIFETIME BENEFIT

The maximum lifetime medical and pharmacy benefits the PPO/PPO Consumer Choice plan will pay is \$2,000,000 per person.

Covered charges incurred by a covered member for TMJ care (*diagnostic testing* and *non-surgical benefits*), organ and tissue transplant services, home hyperalimentation, and mental health/substance abuse treatments have separate annual maximum and/or separate maximum lifetime benefits.

The annual and/or lifetime maximum amount for TMJ care (*diagnostic testing* and *non-surgical benefits*), organ and tissue transplant, home hyperalimentation, and/or mental health/substance abuse treatment, is applied to the \$2,000,000 per person maximum lifetime medical benefit.

- There is a separate lifetime limit of \$1,100 for the *diagnostic testing* and *non-surgical* treatment of *Temporomandibular Joint Disorders (TMJ)* or *orofacial pain*. Covered medical benefits would include diagnosis, x-ray, splinting, physical therapy, and subsequent follow-up treatments.
- *Organ and Tissue Transplant* services have a maximum lifetime benefit limit of \$500,000. The lifetime benefit limit for expenses related to the donor search for an individual who uses a contracted transplant center is \$10,000. This donor search benefit is included in the \$500,000 Organ and Tissue Transplant maximum lifetime benefit. ***Prior approval is required.***
- There is a lifetime limit of \$500,000 for *Home Hyperalimentation*.
- There are annual and lifetime maximum benefit limits for both inpatient and outpatient *Mental Health and Substance Abuse* treatment services.

To receive the highest level of mental health and substance abuse benefits, a member must be pre-certified.

Inpatient Facility:

The maximum benefit for *Mental Health and Substance Abuse* services rendered at an inpatient facility is 60 combined mental health and substance abuse days per person per plan year. ***Pre-certification is required.***

Limits on the Number of Visits/Consultations Provided by a Healthcare Professional at an Inpatient Facility:

- (A) The maximum number of visits/consultations that may be rendered by a network provider, at an inpatient facility, is limited to 60 visits per person per plan year.
- (B) The maximum number of visits/consultations that may be rendered by a non-network provider, at an inpatient facility, is limited to 25 visits per person per plan year.

Substance Abuse Lifetime Limit:

Inpatient treatment for substance abuse is limited to 3 episodes per lifetime.

▪ *Partial/Day Hospitalization & Intensive Outpatient:*

The maximum benefit for *Mental Health and Substance Abuse* partial/day hospitalization and intensive outpatient services is 30 combined visits/days per person per plan year. ***Benefit coverage is available only at in-network facilities.***

▪ *Outpatient Care:*

The maximum benefit for outpatient *Mental Health and Substance Abuse* services is 50 combined mental health, substance abuse, and brief-therapy visits per person per plan year.

Limits on the Number of Outpatient Care Visits/Consultations Provided by a Healthcare Professional:

(A) The maximum number of visits/consultations that may be rendered by a network provider is limited to 50 visits per person per plan year.

(B) The maximum number of visits/consultations that may be rendered by a non-network provider is limited to 25 visits per person per plan year.

Brief-therapy Annual Limits (Outpatient Care):

Three of the 50 combined mental health and substance abuse visits may be used for brief-therapy consultations.

A brief-therapy visit is defined as a form of situational counseling, typically lasting 30 minutes or less. ***A network provider must conduct the brief-therapy sessions. Pre-certification is required.***

ADMINISTRATIVE AGENTS/BUSINESS ASSOCIATES

The current administrative agents/business associates for the University System of Georgia PPO/PPO Consumer Choice healthcare plans include:

(A) Wellpoint/Blue Cross Blue Shield of Georgia

- Provides customer service; and
- Provides claims administration services.
- Provides pre-certification for specific outpatient and all inpatient hospital services;
- Provides case management services;
- Provides access and education regarding 360° Health Programs;
- Provides access to organ and tissue transplant network Centers of Expertise;
- Provides access to 24/7 NurseLine
- Provides the network of hospitals, facilities and medical providers within Georgia, Nationally and Internationally
- Provides behavioral health and substance abuse services.

(B) Medco

- Provides pharmacy benefit program services.

HOW YOUR PPO/PPO CONSUMER CHOICE HEALTH BENEFITS PLAN WORKS

The PPO/PPO Consumer Choice healthcare plan covers only eligible charges that are:

- **Medically necessary:** A service or treatment, which in the judgment of the PPO/PPO Consumer Choice healthcare plan is both appropriate and consistent with the medical diagnosis. To meet the plan's criteria for medical necessity, any service or treatment must be widely accepted professionally within the United States as effective, appropriate, and essential. The treatment or service must be based on recognized standards of the healthcare specialty involved. The treatment or service may not be experimental in nature; educational; or primarily for research or investigations.
- **Prescribed by a physician:** A *physician* is defined to include a doctor of medicine, a doctor of osteopathy, a doctor of dental surgery, a doctor of dental medicine, or a doctor of podiatric medicine. A physician must be legally licensed by the Composite Board of the State of Georgia (or a similar board in any other state) to practice medicine and/or perform surgery.

The following professionals are considered to be providers under the PPO/PPO Consumer Choice healthcare plan, when acting within the scope of their licenses and when rendering services as defined by the plan. These professionals include optometrists; clinical psychologists (Ph.D.), licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, and Masters-level Registered Nurses (RN) called Clinical Nurse Specialists.

Within the PPO/PPO Consumer Choice network rate: A PPO/PPO Consumer Choice member, who uses a *Network* provider, will be charged only the network rate that has been negotiated for medical services. When you obtain health care services through BlueCard outside the geographic area the Claims Administrator serves, the amount you pay for Covered Services is usually calculated on the **lower** of:

1. The billed charges for your Covered Services, or
2. The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to the Claims Administrator.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specific group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specific group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over or under estimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Participant liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should and state statutes mandate Participant liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claims Administrator would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

The member will not be subject to balance billing when using either a Georgia Network and/or a National Network provider.

A plan member who uses any *Out-of-Network* provider will receive a lower level of benefit coverage. A plan member, who uses any Out-of-Network provider, will be subject to balance billing for any medical charges in excess of the eligible charges.

- ***Covered by the PPO/PPO Consumer Choice healthcare plan:*** There are certain medical treatments, services and expenses that are not covered by the plan. Such is the case with the University System of Georgia PPO/PPO Consumer Choice healthcare plans. A number of these are identified in this booklet.

THE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN OPTION

The Preferred Provider Organization (PPO) Plan is a comprehensive network of healthcare providers and facilities that have signed direct contracts with a medical network. The comprehensive medical network provides treatment and services at discounted rates. These network contracts help reduce your out-of-pocket medical expenses for *in-network* physicians, hospitals and ancillary services. “*Ancillary services*” would include those medical services such as physical therapy, laboratory work, and home healthcare.

To participate in a medical network, a provider must meet the credentialing standards established by that network. Network providers must agree to accept the network fee schedule as the maximum amount that a member will be required to pay for medical services. This means that a network provider may not bill a member for an amount that exceeds the network contracted rate. In addition, a participating network provider will prepare and file all medical claims for a PPO healthcare plan member. ***Plan benefits are paid directly to participating network physicians, hospitals and ancillary providers.***

It is always your choice to select and use either an in-network provider or an out-of-network provider. Please be reminded that if you use an out-of-network provider, you will receive a lower level of benefit coverage. Many out-of-network providers will not file your medical claims for you.

Please, also, be informed that an out-of-network provider has not signed an agreement to accept the network’s fee schedule as the maximum payment amount for services rendered. This means that you may be subject to balance billing. ***Please be reminded that member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).***

PLEASE NOTE:

The University System of Georgia PPO/PPO Consumer Choice healthcare plan does not have the legal authority to intervene when a non-participating provider balance bills the member. Therefore, the healthcare plan cannot reduce or eliminate balance billed amounts. The healthcare plan will not make additional payments above the plan allowed benefit limits.

To determine if your doctor is a participating network physician, please ask him or her. When visiting a new physician, or when being referred to a specialist, it is wise to check in advance to determine if he/she is a participating network physician. To determine if your hospital is a participating network facility, please consult with the hospital.

Please be advised, if a provider is not in-network but providing services through an in-network facility, reimbursement will be made according to the individual providers' contract and not the facility. Therefore, please be sure to verify all providers for scheduled procedures are in-network (i.e. anesthesiologist, radiologist and pathologist)

Information regarding the BCBSGa Georgia Network of physicians or hospitals, and information regarding the BlueCard National Network of physicians and hospitals, may be obtained from the Blue Cross Blue Shield of Georgia (BCBSGa) Customer Service unit at 1-800-424-8950 or TDD/404-842-8073. These telephone numbers are listed on your PPO member identification card. In addition, two websites are available to assist you with identifying network providers. You may visit the University System of Georgia website at: www.usg.edu/employment/benefits/health/ or the provider network website at www.bcbsga.com.

PPO/PPO CONSUMER CHOICE BCBSGa GEORGIA IN-NETWORK

Specifically in Georgia, BCBSGa provides you with a network of physicians, hospitals, ambulatory surgery centers, imaging centers, behavioral health, non-MD providers and ancillary health care providers through the BlueChoice Preferred Provider Organization for the PPO. The BlueChoice Preferred Provider Organization is made up of 6,215 Primary Care Physicians and 17,170 Specialty Care Physicians. This represents approximately 80 percent of available physicians in the state. This network also includes 152 hospitals.

NATIONAL AND INTERNATIONAL NETWORK

Unique to BCBSGa, we have reciprocal arrangements with all Blue Cross Blue Shield plans which are located in all states. These arrangements allow us to use their established networks. Each network is owned by a local independent Blue Cross and/or Blue Shield plan. Nationwide, more than 94 percent of hospitals and approximately 84 percent of physicians contract directly with Blue Cross Blue Shield Companies. This percentage translates into over 6,300 hospitals over 466,600 specialists and over 261,200 primary care physicians.

As the plan insures the member, we are called the home plan. The plan providing services to the member who lives or travels outside the home plan's domain is called the host plan. When the member visits an institutional or professional provider outside of our service area, the provider submits the claim to the host plan for payment.

For members working or traveling abroad, a network of hospitals and physicians is available to offer members services throughout the world at no additional cost. At the physician and outpatient level, the member will need to pay for the services at the time they are performed. The member will then submit an international claim form along with the original bill for the charges to the BlueCard Worldwide® Service Center, where they will be translated and the currency converted to U.S dollars. The claim will then be processed through the Blue Cross and Blue Shield system with payment issued to the member. At the hospital level, if the BlueCard Worldwide Service Center arranged the hospitalization, the claim will be automatically submitted to BlueCard Worldwide and there is no up-front member payment required other than the out-of-pocket expenses the member would normally pay (for example: deductible, copayment). While the program negotiates rates, it does not negotiate provider discounts.

Please be reminded that if you use an out-of-network hospital, you will receive a lower level of benefit coverage. Please also be informed that an out-of-network hospital has not signed an agreement with the network to accept the network's fee schedule as the maximum payment amount for services rendered. This means that you may be subject to balance billing.

PPO CONSUMER CHOICE PLAN OPTION

The PPO Consumer Choice Plan Option was established by Georgia statute in 1999. The statute permits a PPO participant to nominate a Georgia out-of-network healthcare provider to render medical care to the covered member at the Georgia Network level of benefit coverage. A physician or hospital must:

- Have a valid Georgia medical license;
- Have an office/facility located within the State of Georgia;
- Agree to the contractual terms and conditions for network providers established by BCBSGa;
- Accept the reimbursement rates/fee schedule established by BCBSGa.

A member may nominate a PPO Consumer Choice healthcare provider at any time, prior to using the provider. Please be informed that a member **may only enroll in the PPO Consumer Choice Plan Option** during an open enrollment period or at the time of his/her initial employment. If you wish to obtain a PPO Consumer Choice provider nomination form, please contact BCBSGa Customer Service at 1-800-424-8950.

A plan member must complete a PPO Consumer Choice Plan Option nomination form for each selected out-of-network provider. The completed nomination form must be submitted to BCBSGa for its review and for its decision to accept/deny the nomination.

If BCBSGa does not accept a nominated provider, or if a nominated provider chooses not to accept a member's nomination, the member ***may not*** change from the PPO Consumer Choice Plan Option until the following scheduled open enrollment period. The healthcare premium for a member who elects the PPO Consumer Choice Plan Option will be greater than the healthcare premium for a member who elects the standard PPO healthcare plan.

Please be reminded that if a nominated healthcare provider agrees to accept a member's nomination and, if the healthcare provider is approved by BCBSGa for participation in the PPO Consumer Choice Plan Option, the Georgia Network relationship exists only between the provider and the designated patient. The Georgia Network relationship between the approved provider and the patient has no time limit. The relationship will remain in effect until either the provider or the patient terminates the relationship. The provider does not become a part of the regular Georgia Network BCBSGa PPO provider network.

WELLNESS CARE/PREVENTIVE HEALTHCARE

The PPO/PPO Consumer Choice healthcare plans will provide wellness benefits of up to \$750 per person per plan year. The wellness benefit is paid at 100% of the network rate, after a \$20 office visit co-payment. The benefit is not subject to a deductible. The wellness care/preventive healthcare benefit is covered only if a PPO member uses either, a Georgia Network or a National Network provider. *The maximum wellness benefit that a covered member may receive when using Georgia Network and/or National Network providers is \$750 per person per plan year.*

Charges for wellness services in excess of the annual \$750 maximum level benefit are not eligible for reimbursement under any other category of plan coverage. Wellness care/preventive healthcare services include:

- Routine physical exams;
- Routine mammograms;
- Pap smears;
- Prostate exams/PSA;
- Well-baby care and immunizations;
- Adult immunizations;
- Routine eye exams (either an ophthalmologist or an optometrist may provide wellness vision care services); and
- Routine hearing exams.

Under this benefit, well-baby care includes routine physical exams, immunizations, x-rays, laboratory tests, and other tests billed by the attending physician for services rendered in his/her office. Treatment of suspected/identified injuries or illnesses *and* allergy injections ***are not*** covered by the wellness benefit. Wellness care/preventative healthcare services provided by a Campus Health Center, County Health Department or a Wellness Fair, ***are not*** covered by the wellness benefit.

TREATMENT OF DISEASES OF THE EYE

The PPO/PPO Consumer Choice plan design includes coverage for the treatment of diseases of the eye. Under Georgia statute, a plan design that provides benefits coverage for the treatment of diseases of the eye must include optometrists as providers for vision care services.

Ophthalmologists are medical doctors (MD); are licensed to perform eye-related surgical procedures; and are involved with the treatment of vision-related conditions and diseases of the eye. An optometrist may perform vision care services involving the treatment of conditions and diseases of the eye that are non-surgical in nature.

To assist you in understanding the difference between the types of services that an optometrist may render as compared to those that an ophthalmologist may render, please consider the following example. An optometrist may provide vision care services that would be employed to diagnose a cataract, but he/she would not be able to perform corrective cataract surgery. An ophthalmologist, as a licensed medical doctor, would be able to perform corrective cataract surgery.

The purchase of eyewear (glasses/contact lenses) ***is not*** a covered benefit under the wellness/preventive care program. However, one pair of eyewear (glasses/contacts) is covered following cataract surgery.

The PPO/PPO Consumer Choice healthcare plan requires that an optometrist be located within the state of Georgia to be considered as a Georgia Network provider. A PPO/PPO Consumer Choice member will be required to pay a \$20 office visit co-payment.

Please be informed that the National Network also includes ophthalmologists and optometrists for your use outside of the Georgia Network service area.

BlueChoice Vision Program through Special Offers

Blue Cross Blue Shield of Georgia (BCBSGa) has established member-discounted vision services contracts. Enjoy up to a 30% savings on a complete pair of prescription glasses, most sunglasses and lens options at thousands of providers nationwide. Members can choose from private practitioners or leading optical retailers such as LensCrafters, Target Optical, JCPenny Optical and most Pearle Vision locations. To receive the discounted rate, please present your member identification card to any participating *BlueChoice Vision* provider. For a listing of the *BlueChoice Vision* participating providers, please contact the BCBSGa customer service unit at 1-800-424-8950/TDD 404-842-8073 or visit the BCBSGa Special Offers website at www.bcbsga.com. Please be informed that the *BlueChoice Vision Program* is a vision services discount program; not an employee benefit.

SECOND MEDICAL OPINION FOR ELECTIVE SURGERY

A member is permitted to obtain a second medical opinion for an elective surgery. The PPO/PPO Consumer Choice healthcare plan will cover 100% of the network rate after a \$20 office visit co-payment for a second medical opinion, ***when using an in-network provider***. The charges for the second physician's consultation services are not subject to a deductible. Please be reminded that an elective surgery must be deemed to be medically necessary to receive plan benefits. Precertification may be required.

Decisions regarding an elective surgery will continue to be the joint responsibility of the member and his/her physician. Please be informed that the plan ***will not*** provide benefits coverage for inpatient hospital consultations associated with an elective surgery.

MEDICAL UTILIZATION MANAGEMENT REVIEW PROGRAM

The Medical Utilization Management Review program is comprised of three components. These components are integrated to ensure that the highest degree of patient care is provided during every stage of treatment for an illness or injury:

- ***Pre-certification Review:***

Specific Outpatient Medical Procedures - To access benefits coverage for specific outpatient medical procedures/diagnostic testing, BCBSGa must determine if: (1) the procedure is

medically necessary; and/or (2) if an appropriate and alternative treatment is available. For the specific listing of outpatient procedures that require BCBSGa pre-certification, please review the section entitled, “*Pre-certification for Certain Outpatient Procedures/Diagnostic Tests*”, located on pages 41-43.

Outpatient pre-certification review is not required for covered retirees/covered spouses of retirees who have Medicare Part B. In this instance, Medicare Part B would provide primary coverage and the University System of Georgia PPO/PPO Consumer Choice healthcare plan would provide secondary coverage.

Inpatient Hospital Admissions - To access benefits coverage for inpatient hospital admissions, BCBSGa must determine if: (1) the procedure and/or admission is medically necessary; and/or (2) if an appropriate and alternative treatment is available.

For an inpatient hospital admission, a pre-certification review is not required for covered retirees/covered spouses of retirees who have Medicare Part A. In this instance, Medicare Part A would provide primary coverage and the University System of Georgia PPO/PPO Consumer Choice healthcare plan would provide secondary coverage.

- ***Continued Inpatient Hospital/Medical Facility Confinement Review:***

During an approved hospital/medical facility confinement, BCBSGa will monitor a patient’s progress by consulting with his/her attending physician. BCBSGa will consult with the attending physician to ensure that the recommended treatment plan is consistent with medical benefits covered by the healthcare plan design. BCBSGa will, also, review and render decisions for requests to extend periods of inpatient hospital/medical facility confinement.

- ***Available Alternative Medical Services/Care Review Process:***

BCBSGa will identify patients for whom early discharge from a hospital/medical facility to a home healthcare environment is appropriate. BCBSGa will identify a home healthcare agency to provide necessary services/care for the patient. Home healthcare agency treatment plans for the patient will be monitored by BCBSGa.

Under the Medical Utilization Management Review program, BCBSGa must review all of the following:

- Hospital confinements, including emergency room admissions and surgery;
- Certain outpatient procedures and diagnostic testing;
- Organ and tissue transplants;
- Home healthcare;
- Home hyperalimentation;
- Hospice care; and
- Private duty nursing.

PLEASE NOTE: Precertification (PAC)

In-Network Care

If you are hospitalized other than for an emergency or a maternity delivery admission and pre-admission certification was not obtained, all charges will be denied. You will be held harmless if all network guidelines are followed and you were admitted to a Preferred or Participating Hospital. This means you will not be responsible for any bill in excess of the related Deductible, Coinsurance that applies, and Non-Covered Services.

If your stay exceeds the number of days assigned under this Plan, the Hospital's charge for additional days beyond the assigned length of stay will not be paid. If all In-Network guidelines are followed you will not be responsible for any Eligible Charges except the normal Deductible, Coinsurance and Non-Covered Services.

Ineligible Charges and Non-Covered Services are always the Participant's responsibility.

PAC is the responsibility of the Preferred Hospital or Preferred Physician.

Out-of-Network Care

You, the Physician or the Hospital **must** obtain approval for all Hospital admissions except for an emergency or a maternity delivery admission.

If you are hospitalized other than for an emergency or a maternity delivery admission and pre-admission certification was not obtained, all charges will be denied. You will be responsible for all Hospital charges.

If you obtain PAC but exceed the number of days allowed through the PAC process, you will be responsible for all of the charges for those days.

Ineligible Charges are always the Participant's responsibility.

If you are admitted to a Preferred or Non-Preferred Hospital and the admission is determined not to be Medically Necessary, all charges for that admission and related Physician charges will be Ineligible Charges.

Out-of-Network Providers are under no obligation to hold you harmless for those charges, so you may be responsible for the full amount of all of those charges.

If PAC is not obtained, **you** will be responsible for all charges. Any days exceeding the authorized length of stay will be denied and **you** will be responsible for all related charges.

Precertification (PAC) (cont'd)

Remember: PAC is not a guarantee of payment.

If you are admitted to a Hospital and the admission is determined NOT to be Medically Necessary, no benefits will be provided for that admission and related Physician charges. **You** will be responsible for all charges.

The final decision regarding the appropriate level of medical treatment for you and your family continues to be the joint responsibility of you and your physician. The Medical Utilization Management Review program is designed to evaluate medical alternatives. It is not designed, nor intended, to practice medicine. The review process does not replace the medical advice of your physician; the review process ensures that you are aware of all medical options before you receive care.

The Medical Utilization Management Review program ensures that you and your family receive medically necessary treatment. The program also assists you in avoiding unnecessary expenses.

Should you elect to receive home healthcare, hospice care, or private duty nursing services, ***without the prior approval of BCBSGa, no plan benefits will be paid.***

MATERNITY AND NEWBORN INFANT NURSERY CARE BENEFITS

After meeting your appropriate deductible, the plan will pay 90% of the *Georgia Network* contracted rates for covered hospital charges. After meeting your appropriate deductible, the plan will pay 80% of the *National Network* contracted rates for covered hospital charges.

After an initial \$20 office visit co-payment, the plan will pay the appropriate network (*Georgia Network or National Network*) rate for covered physician charges. Physician expenses include prenatal, delivery, and postnatal care. Please be reminded that if you use an out-of-network provider, you will receive a lower level of benefit coverage and you are subject to balance billing.

Upon the birth of the newborn, the covered newborn begins to establish his/her own individual hospital charges. The covered newborn will not be required to establish a separate and individual deductible, ***unless*** the covered newborn continues to be hospitalized after the discharge of the mother. Covered charges, incurred by the newborn, will be paid by the healthcare plan at the appropriate benefit level.

Maternity care benefits are provided for a covered employee; a covered spouse; and/or a covered, unmarried dependent female child. Maternity care benefits are covered for licensed birthing centers and for services provided by a certified nurse midwife.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT OF 1996

Congress has passed the Newborns' and Mothers' Health Protection Act of 1996. This federal statute created a minimum length of inpatient hospital care that must be provided for mothers and newborns having healthcare coverage under a group or individual healthcare plan. The respective University System of Georgia healthcare plans comply with this federal mandate.

The minimum length of inpatient care will vary depending upon the medical condition of the mother. The minimum length of stay following a normal vaginal delivery is 48 hours and the minimum length of stay following a cesarean section is 96 hours. If the attending physician, in consultation with the mother, decides to discharge the mother and/or newborn prior to the mandated minimum stay, the hospital confinement requirements will not apply.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Congress has passed the Women's Health and Cancer Rights Act of 1998. This federal statute requires that group health insurance plans provide its participants with certain benefits for reconstructive surgery and/or complications related to a mastectomy. The respective University System of Georgia healthcare plans comply with this federal mandate.

The federal statute requires that a group healthcare plan provide coverage for:

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

The attending physician and the patient will discuss an appropriate medical treatment plan that may be shared with BCBSGa.. The recommended treatment plan may be reviewed and approved by BCBSGa. Benefits coverage will be subject to the same deductible and coinsurance provisions that apply to the other medical and/or surgical benefits of this healthcare plan.

PRE-CERTIFICATION FOR CERTAIN OUTPATIENT PROCEDURES/DIAGNOSTIC TESTS (PLAN YEAR 2005)

Certain outpatient procedures and diagnostic tests will require pre-certification. As soon as your physician recommends an outpatient procedure for you or for a covered dependent, please ask your doctor to provide you with the CPT code for that procedure. You may then contact the Medical Utilization Management Review Program (1-800-233-5765/TDD 1-800-368-4424) or the BCBSGa customer service unit (1-800-424-8950/TDD 404-842-8073) to determine whether pre-certification is required.

If a procedure or diagnostic test requires pre-certification, your *Georgia Network physician will be responsible for contacting* the Medical Utilization Management Review Program *at least 48 hours prior to the scheduled procedure*, unless the procedure is an emergency. If you receive medical care from a *National Network provider, or from an Out-of-Network provider*, it will be *your responsibility to contact* the Medical Utilization Management Review Program *a minimum of 48 hours prior to your scheduled procedure*.

Description CPT Code

MRIs:

Cervical 72141, 72142, 72156
Thoracic 72146, 72147, 72157
Lumbar 72148, 72149, 72158
Abdomen 74181 – 74183
Pelvis 72195 – 72197
Extremity: Upper (Nonjoint) 73218 - 73220
Extremity: Upper (Joint) 73221 - 73223
Extremity: Lower (Nonjoint) 73718 - 73720
Extremity: Lower (Joint) 73721 - 73723
Chest 71550 – 71552
Orbit, Face, Neck 70540 – 70543
Miscellaneous (3D or Holographic Reconstruction of a CT, MRI or
Other Tomographic Modality)
76376 or 76377

Pet Scans

Brain 78608, 78609
Cardiac 78459, 78491, 78492
Miscellaneous 78811 -78816, G0219
Reconstruction Nasal Septum/Septo 30620
Rhinoplasty 30400 – 30520
Sleep Studies 95805 - 95808, 95810, 95811
Nasal Surgeries 30930
Upper GI Endoscopy/EDG 43234, 43235, 43236, 43239
Uvulopalatopharyngoplasties 42120, 42140, 42145, 42299

CAT Scans:

Neck – Soft Tissue 70490, 70491, 70492
Thorax 71250, 71260, 71270
Chest (Ultrafast CT) 71275
Pelvis 72192, 72193, 72194
Upper Extremity 73200, 73201, 73202
Lower Extremity 73700, 73701, 73702
Abdomen 74150, 74160, 74170
Miscellaneous 76380

CT Angiography (CTA)

Thorax 71260 & 71270

Chest (noncoronary) 71275

Abdomen 74175

Abdominal aorta 75635

Pelvis 72191

Upper Extremity 73206

Lower Extremity 73706

Heart 0144T, 0146T, 0147T, 0148T, 0149T, & S8092

Colonoscopy 45378 - 45385

Insulin Pump E0784

MRAs:

Chest 71555, C8909-C8911

Upper Extremity 73225,

Lower Extremity 73725, C8912-C8914

Abdomen 74185, C8900-C8902

Pelvis 72198, C8918-C8920

Spinal Canal 72159

PLEASE NOTE:

In-Network Care

If you are hospitalized other than for an emergency or a maternity delivery admission and pre-admission certification was not obtained, all charges will be denied. You will be held harmless if all network guidelines are followed and you were admitted to a Preferred or Participating Hospital. This means you will not be responsible for any bill in excess of the related Deductible, Coinsurance that applies, and Non-Covered Services.

If your stay exceeds the number of days assigned under this Plan, the Hospital's charge for additional days beyond the assigned length of stay will not be paid. If all In-Network guidelines are followed, you will not be responsible for any Eligible Charges except the normal Deductible, Coinsurance and Non-Covered Services.

Ineligible Charges and Non-Covered Services are always the Participant's responsibility.

PAC is the responsibility of the Preferred Hospital or Preferred Physician.

Out-of-Network Care

You, the Physician or the Hospital **must** obtain approval for all Hospital admissions except for an emergency delivery admission.

If you are hospitalized other than for an emergency or a maternity delivery admission and pre-admission certification was not obtained, all charges will be denied. You will be responsible for all Hospital charges.

If you obtained PAC but exceed the number of days allowed through the PAC process, you will be responsible for all of the charges for those days.

Ineligible Charges are always the Participant's responsibility.

If you are admitted to a Preferred or Non-Preferred Hospital and the admission is determined not to be Medically Necessary, all charges for that admission and related Physician charges will be Ineligible Charges.

Out-of-Network Providers are under no obligation to hold you harmless for those charges, so you may be responsible for the full amount of all of those charges.

If PAC is not obtained, **you** will be responsible for all charges. Any days exceeding the authorized length of stay will be denied and **you** will be responsible for all related charges.

Remember: PAC is not a guarantee of payment.

If you receive one of the above mentioned services that require precertification and it is determined NOT to be Medically Necessary, no benefits will be provided for that service and related Physician charges. **You** will be responsible for all charges.

MEDICAL CASE MANAGEMENT

The Medical Case Management program, administered by BCBSGa, is designed to assist with the complexities and costs of a catastrophic illness or injury. This program employs early intervention strategies to identify such cases. The program provides continuous medical case management from hospitalization through discharge and recovery. BCBSGa physicians, case managers, and rehabilitation specialists, work with a patient's attending physician to facilitate the most appropriate medical treatment and setting. The Medical Case Management program is automatically activated by BCBSGa when a member experiences a catastrophic illness or injury.

HOME HEALTHCARE SERVICES

After meeting your appropriate deductible, the plan will pay 90% for *Georgia Network* home healthcare services covered charges. After meeting your appropriate deductible the plan will pay 80% for *National Network* home healthcare services covered charges.

These respective home healthcare services covered charges do not apply to the annual maximum out-of-pocket limits (stop loss).

Home healthcare services are limited to 2 hours of care within a 24-hour day. The home healthcare benefit is limited to \$7,500 per person per plan year. ***BCBSGa must review and pre-certify all home healthcare services.***

Home healthcare services that are covered include:

- Visits for part-time or occasional nursing care provided by an appropriate home healthcare professional;
- Short term rehabilitation services. Your benefit provides for: ***physical, speech, cardiac and occupational therapies*** that are limited to a maximum of 40 visits per incident type per plan year. To receive a benefit for ***speech therapy***, there must be a medically diagnosed condition of inability to speak/loss of speech due to illness, surgery, or birth defect. Services must be provided by a qualified speech therapist.
- Medical supplies, prescribed medications, and laboratory services, if such services would have been provided in a hospital; and
- Nutritional counseling that is provided or supervised by a registered nurse (RN).

Home healthcare services that ***are not*** covered include:

- Service or supply that is not included in a BCBSGa approved home healthcare plan;
- Custodial care;
- Services provided by a family member; and
- Services or supplies that is experimental in nature.

DURABLE MEDICAL EQUIPMENT (DME)

For one to receive benefit coverage for durable medical equipment (DME), the DME must serve to improve or maintain a patient's mobility and/or function. DME must be consistent with the patient's physical disorder. The equipment must be prescribed by an attending physician and must be appropriate for in-home use. Examples of DME include wheelchairs or hospital-type beds.

DME must meet the following criteria:

- It must be able to withstand repeated use;
- It must be manufactured solely to serve a medical purpose;
- It must not be merely for comfort or convenience; and
- It must be useful for an ill or injured patient.

The plan coverage for DME is based on the network charges for basic equipment. The benefit for deluxe equipment, including prosthesis, will be limited to the network fee for the basic version of that specific type of equipment. The PPO/PPO Consumer Choice healthcare plan will determine whether DME should be rented or purchased. Approved rental fees will not be permitted to exceed the cost of purchasing the DME.

Based upon a physician's prescription for DME, you and/or your physician will be required to contact BCBSGa. BCBSGa will determine if the recommended DME meets the plan criteria for medical necessity and/or requires pre-certification. BCBSGa will make such decisions on a case-by-case basis. Please contact BCBSGa at 1-800-233-5765/TDD 1-800-368-4424.

Some of the DME items that *are not* covered by the PPO/PPO Consumer Choice healthcare plan include, but are not limited to:

- Air conditioners, humidifiers, dehumidifiers or purifiers;
- Motor-driven chairs or beds, when standard equipment is adequate;
- The rental or purchase of equipment if a member is in a hospital/facility;
- Pools, spas, and whirlpools;
- Electric stair chairs or elevator chairs;
- Physical fitness, exercise or ultraviolet-tanning equipment;
- Foot care devices including arch supports, orthopedic or corrective/custom made shoes;
- Heating pads, hot water bottles, home enema equipment, or rubber gloves;
- Electric toothbrushes;
- Home supplies, such as first aid items; and
- Blood pressure monitors

HOSPICE CARE SERVICES

A hospice program provides for the care and counseling of terminally ill patients and their families. After meeting the Georgia Network, or the National Network deductible, the plan will pay for 100% of covered charges for hospice care services. ***BCBSGa must review and pre-certify all hospice care services.***

Hospice care services that are covered include:

- Semi-private room and board;
- Local ambulance or special transport service between the terminally ill patient's home and the hospice facility;
- Medical supplies, prescribed medications, and laboratory services;
- Dietary counseling by a licensed nutritionist or dietician;
- Physical, respiratory or speech therapy;
- Homemaker services for a maximum of seven (7) days;
- Part-time nursing care by a registered nurse (RN) or a licensed practical nurse (LPN);
- Counseling services for the patient, or for the family learning to cope with a terminally ill patient. Counseling services will be for no longer than six months; and
- Assistance with the identification and access to available community resources.

Hospice care services that ***are not*** covered include:

- Funeral arrangements;
- Financial or legal counseling;
- Counseling by clergy or any volunteer group;
- Care furnished by family member or someone who lives in the terminally ill patient's home;
- Private duty nursing; and
- Volunteer services or services normally free of charge.

360° HEALTH PROGRAMS

Through the seamless total management approach of our 360° Health programs, we offer our members programs and services that have a wide-ranging suite of preventive care, wellness information, lifestyle behavior management, condition management programs and complex care support – all designed to deliver the right services to the right members at the right time.

ConditionCare programs that BCBSGa is offering to BOR PPO Members are:

- Asthma: (Adult & Pediatric)
- Diabetes: (Adult & Pediatric)
- Heart Failure:
- Coronary Artery Disease:
- Chronic Obstructive Pulmonary Disorder:

BCBSGa is also offering a customized MyHealth Coach program that will address cancer, hypertension, hyperlipidemia, musculoskeletal conditions and low back pain.

Program Descriptions

Below are brief descriptions of the programs. In addition, our nurses are trained to handle all conditions including any existing co-morbidities. BCBSGa's holistic approach to member care achieves better outcomes by focusing on the member's overall health and addresses all conditions and co-morbidities as they relate to and affect the member's ability to manage their overall health.

Asthma (adult and pediatric)

BCBSGa's program for asthma assigns primary nurse care managers to work closely with those members identified as requiring ongoing one-on-one management and education. This strategy helps to minimize risk and improve outcomes by developing effective self-management regimens that include asthma trigger avoidance and medication compliance.

Diabetes (adult and pediatric)

Diabetes management is complicated and often overwhelming. BCBSGa's nurse care managers and supporting health professionals, including certified diabetic counselors, collaborate to help members avoid health complications through effective lifestyle changes. BCBSGa's program helps members follow their treating physician's plan of care, undergo regular blood testing and screenings and observe a healthier diet. Registered dietitians, as well as other support staff also help in supporting the management of the member's conditions and co-morbidities.

Additionally, BCBSGa supports providers with diabetic education and nutritional counseling information available through the ConditionCare programs. BCBSGa also encourages providers to refer members to the ConditionCare programs where members have access to BCBSGa dietitians for nutritional counseling and nurse care managers for additional diabetic education.

Heart Failure (HF) and Coronary Artery Disease (CAD)

Adherence to the treating physician's plan of care for prescribed medications, diet and exercise can help members with heart failure (HF) and/or coronary artery disease (CAD) avoid the need for costly emergency room visits and hospital admissions. Through helpful condition-specific education, BCBSGa's programs are designed to help members become better self-managers of their condition

and live fuller lives. Members in any of BCBSGa's ConditionCare programs have 24-hour toll-free access to experienced nurse care managers for questions about their condition and its management.

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) often becomes more serious the longer a person has the condition. But with BCBSGa's targeted COPD program, the condition's advance can be slowed so that members can live a more normal and healthier life. For those members who are stable and controlled, the program gives members access to a staff of experienced registered nurses who are available through a convenient toll-free phone number to answer questions about how best to live more fully with COPD. BCBSGa also has licensed pharmacists on staff to counsel members about how to take their physician-prescribed medications for maximum effectiveness.

An assigned nurse care manager provides ongoing telephonic management and education to members requiring higher intensities of targeted care for their COPD. This nurse calls on a regular basis to help ensure appropriate management of the member's condition. BCBSGa's nurse care managers also help members to understand the treating physician's plan of care and collaborate as necessary with program pharmacists and dietitians to help achieve designated health goals.

MyHealth Coach

BCBSGa's Health Advocacy program, called MyHealth Coach, targets the top tier of health care users. MyHealth Coach nurses serve as a central point of contact for individuals who have questions about a health care related topic, condition or concern, a question about benefits, a concern about claim payment or language in an 'Explanation of Benefits' statement.

BCBSGa nurses follow the member through their inpatient admission with pre-admission counseling and clinical education that follows a member through medically appropriate intervention points specific to the severity of the member's condition and treatment plan. Additionally, MyHealth Coaches perform post-discharge planning which may require arranging for services like outpatient rehabilitation or home health care. MyHealth Coaches also reach out to members before and after hospitalizations to ensure members are prepared both before they go in for a procedure and once they are discharged.

MyHealth coaches can also find the appropriate providers for the member. Additionally, if the MyHealth Coach RN finds that the member would be more appropriately managed through one of BCBSGa's ConditionCare or transplant programs, the MyHealth Coach program refers the member to the appropriate nurse care manager.

The program offered for BOR members can provide guidance for a wide array of conditions too numerous to list, but will have targeted identification for the following health conditions:

- **Hypertension** – Vascular-related conditions like Hypertension are often associated with an increased risk for other chronic conditions like coronary artery disease (CAD), diabetes, stroke, peripheral vascular disease and peripheral artery disease. MyHealth Coach RNs help to ensure that members most at risk are working toward making changes needed to prevent or delay the development of other serious conditions.
- **Hyperlipidemia** – Like Hypertension, members with this vascular condition can speak with their MyHealth Coach RN can assist those most at risk stay on track with exercise plans, nutrition education and medical compliance.
- **Oncology** (addressing prostate, skin, breast, colon and lung cancer) – For those members requiring the highest level of intervention, a dedicated MyHealth Coach RN works one-on-

one with the participant to assist in reducing or stabilizing clinical severity. MyHealth Coach RNs also provide support through hospitalizations and any post-discharge plans needed.

- **Musculoskeletal** (addressing arthritis and osteoporosis) – By providing education and support to the highest utilizers, BCBSGa aims to help the member develop identification and intervention techniques that improve intervention timing and reduce the impact of future health costs for members afflicted with arthritis or osteoporosis.
- **Low Back Pain** – Though low back pain conditions often improve through conservative, non-surgical therapies, MyHealth Coach RNs are available to assist members in evaluating surgical alternatives and providing support throughout the member's hospitalization, discharge, and rehabilitation needs.

24/7 NURSELINE PROGRAM

24/7 NurseLine is a toll-free, 24-hours a day, seven days a week, medical information service available to you and your covered family members. Whenever you or your family members experience a troubling health symptom, you may speak directly with a registered nurse. Nurse counselors are available to answer questions regarding medical procedures, health symptoms or prescription medications.

Nurse professionals are available to assist you with member referrals to appropriate healthcare providers, to self-help agencies, and/or to hospital emergency rooms/urgent care facilities, as necessary. The toll-free 24/7 NurseLine telephone number is 1-800-785-0006/TDD 1-800-368-4424.

Hospital Emergency Room Care In-network or Out-of-network:

24/7 NurseLine nurses have the authority to issue hospital emergency room referrals. If an emergency room referral is obtained, the level of benefit coverage will be 90% of the network rate after a \$50 member co-payment. If an emergency room referral ***is not*** obtained, the level of benefit coverage will be 90% of the network rate after a \$75 member co-payment. If a member is admitted to the hospital within 24 hours of receiving emergency room care, the member co-payment will be waived.

Please be reminded that when a member is admitted to a National Network hospital, or to an Out-of-Network hospital, he/she must contact BCBSGa within 48 hours after the admission. The toll-free telephone number for BCBSGa is 1-800-233-5765/TDD 1-800-368-4424.

The use of 24/7 NurseLine is *voluntary*. You must decide what level of medical care is appropriate under emergency conditions. If you believe that you and/or your family member are facing a life-threatening situation, please act responsibly. Please go to the nearest medical facility or please call 911, if available in your area. If possible, we encourage you to contact 24/7 NurseLine to obtain timely emergency medical assistance.

The 24/7 NurseLine *audio library* is a medical information service/resource that is available to our plan participants. The audio library, developed by healthcare experts, provides extensive medical information on a variety of health-related topics. You may wish to access the audio library for information on a specific medical condition.

Please call the 24/7 NurseLine toll-free telephone number at anytime, day or night. Should you have additional questions regarding the medical information that you receive, you may transfer to a registered nurse and discuss the medical topic in greater detail. Please be reminded that the audio library should not be used as a substitute for your physician's professional assistance.

The 24/7 NurseLine audio library information is available on the University System of Georgia website at www.usg.edu/employment/benefits/health/. The resource link is [WebMD® Health Database](#).

ORGAN AND TISSUE TRANSPLANT PROGRAM

The Centers of Expertise Program (COE) for organ and tissue transplant services is a national network of credentialed medical providers. Providers are invited to participate in this program based on compliance with established standards of clinical expertise. The Centers of Expertise Program directs patients to network heart, liver, lung, and bone marrow transplant specialists.

The organ and tissue transplant program uses literature-based protocols. These protocols guide COE physicians and members of the COE transplant panel in the completion of medical review determinations. Each member who participates in the *Organ and Tissue Transplant* program will have a Transplant Coordinator. The Transplant Coordinator will introduce the patient to the program; explain the program procedures; and assist the patient with the coordination of any needed home care services. The program provides for patient access to a specialty-matched physician reconsideration process.

The Centers of Expertise Program for organ and tissue transplant services provide members with a higher level of benefit coverage. Participants in this program will receive benefit coverage at 90% of the network rate if a COE contracted transplant center is used. There will be an additional and separate \$100 hospital deductible required from the member, if this benefit is used.

The lifetime benefit limit for expenses related to the donor search for an individual who uses a COE **contracted transplant center** is \$10,000. This donor search benefit is included in the \$500,000 *Organ and Tissue Transplant* maximum lifetime benefit. ***Prior approval is required.***

Please be advised that organ and tissue transplants are covered at 60% of eligible charges at a non-contracted COE transplant center. There will be an additional and separate \$100 hospital deductible required from the member, if this benefit is used. There is no benefit coverage for expenses related to the donor search when using a non-contracted COE transplant center. ***The member will, also, be subject to balance billing.***

Should you desire additional information or should you wish to participate in the Centers for Expertise *Organ and Tissue Transplant* program, please call 1-866-694-0724.

The lifetime maximum benefit limit for the *Organ and Tissue Transplant* program is \$500,000.

COVERED EXPENSES

Please be reminded that certain covered expenses *will require* pre-certification. Please refer to the “*Benefits at A Glance*” section starting on page 2 of this booklet.

INPATIENT HOSPITAL
Georgia In-Network – 100%
National In-Network - 100%

After meeting your deductible, the plan will pay for 100% of the in-network rate for:

- Hospice care services.

INPATIENT HOSPITAL AND PHYSICIAN SERVICES
Georgia In-Network – 90%
National In-Network – 80%

After meeting your deductible, the plan will pay for 90% of the Georgia Network contracted rates; or, for 80% of the National Network contracted rates for:

- Semi-private room and board;
- Observation room stays of less than 24 hours;
- Charges for intensive care unit (ICU), cardiac care unit (CCU), or other similar accommodations;
- Laboratory charges, including x-rays and diagnostic testing/examinations;
- Physician charges for a *surgical* or obstetrical procedure;
- Sterilization procedures, but not reversals;
- Registered nurse (RN) charges for skilled nursing care, including private duty nursing; and
- Organ and tissue transplants are covered at *90% of the vendor network rate* at a COE contracted transplant center. There will be an additional and separate \$100 hospital deductible required from the member, if this benefit is used. The lifetime benefit limit for expenses related to the donor search for members who use a COE transplant center is \$10,000.

INPATIENT HOSPITAL AND PHYSICIAN SERVICES
Out-of-Network – 60%

After meeting your deductible, the plan will pay for 60% of eligible charges for covered inpatient hospital services. (*Please be reminded that you will be subject to balance billing.*) Covered inpatient hospital services include:

- Semi-private room and board;
- Observation room stays of less than 24 hours;

- Charges for intensive care unit (ICU), cardiac care unit (CCU), or other similar accommodations;
- Laboratory charges, including x-rays and diagnostic testing/examinations;
- Physician charges for a surgical or obstetrical procedure;
- Sterilization procedures, but not reversals;
- Hospice care services;
- Registered nurse (RN) charges for skilled nursing care, including private duty nursing; and
- Organ and tissue transplants are covered at 60% of eligible charges at a non-contracted COE transplant center. There will be an additional and separate \$100 hospital deductible required from the member, if this benefit is used. There is no benefit coverage for expenses related to the donor search when using a non-contracted COE transplant center. ***The member will be subject to balance billing.***

OUTPATIENT HOSPITAL/FACILITY SERVICES

Georgia In-Network - 100%

National In-Network - 100%

After meeting your deductible, the plan will pay 100% of the network rate for:

- Services provided through a hospice care program.

OUTPATIENT HOSPITAL/FACILITY SERVICES

Georgia In-Network – 90%

National In-Network – 90%

After meeting your deductible, the plan will pay 90% of the Georgia Network contracted rates; or, 90% of the National Network contracted rates, ***subject to the in-network deductible***, for:

- Emergency room services; if a referral to the emergency room is obtained from 24/7 NurseLine, the member will be required to pay a \$50 co-payment; and
- Ambulance service, for medically necessary emergency transportation, to the nearest facility providing the required treatment.

OUTPATIENT HOSPITAL/FACILITY SERVICES

Georgia In-Network 90%

National In-Network 80%

After meeting your deductible, the plan will pay for 90% of the Georgia Network contracted rates; or, for 80% of the National Network contracted rates for:

- Physician charges;
- Surgical charges associated with the removal of impacted teeth;
- Cochlear implants;

- An outpatient surgical facility selected by a treating physician;
- Home hyperalimentation;
- Treatment provided through an approved home nursing care program;
- Laboratory charges, including x-rays and diagnostic testing/examinations;
- Expenses incurred for rental or purchase of durable medical equipment (DME) or supplies, if medically necessary;
- Urgent care treatment/services provided by a physician, in either an office setting or an urgent care facility;
- Chiropractic care; and
- Outpatient short-term rehabilitation services. Your benefit provides for: ***physical, speech, cardiac and occupational therapies*** that are limited to a maximum of 40 visits per incident type per plan year. To receive a benefit for ***speech therapy***, there must be a medically diagnosed condition of inability to speak/loss of speech due to illness, surgery, or birth defect. Services must be provided by a qualified speech therapist.

OUTPATIENT HOSPITAL/FACILITY SERVICES

Out-of-Network – 90%

Subject to the Network deductible, the plan will pay for 90% of eligible charges for the following covered outpatient hospital/facility services: *(Please be reminded that you will be subject to balance billing.)*

- Emergency room services; if a referral to the emergency room is obtained from 24/7 NurseLine, the member will be required to pay a \$50 co-payment; and
- Ambulance service, for medically necessary emergency transportation, to the nearest facility providing the required treatment.

OUTPATIENT HOSPITAL/FACILITY SERVICES

Out-of-Network - 60%

After meeting your deductible, the plan will pay for 60% of the network rate for: *(Please be reminded that you will be subject to balance billing.)*

- Physician charges;
- Urgent care treatment/services provided by a physician, in either an office setting or an urgent care facility;
- **Surgical** charges associated with the removal of impacted teeth;
- Cochlear implants;

- An out-patient surgical facility selected by a treating physician;
- Home hyperalimentation;
- Treatment provided through an approved home nursing care program;
- Laboratory charges, including x-rays and diagnostic testing/examinations;
- Services provided through a hospice care program;
- Chiropractic care;
- Expenses incurred for rental or purchase of durable medical equipment (DME) or supplies, if medically necessary; and
- Outpatient short-term rehabilitation services. Your benefit provides for: ***physical, speech, cardiac and occupational therapies*** that are limited to a maximum of 40 visits per incident type per plan year. To receive a benefit for ***speech therapy***, there must be a medically diagnosed condition of inability to speak/loss of speech due to illness, surgery, or birth defect. Services must be provided by a qualified speech therapist.

PHYSICIAN SERVICES PROVIDED IN AN OFFICE SETTING

Georgia In-Network – 100%

National In-Network - 100%

For the following four benefits, there is no member deductible. The plan will pay for 100% of the Georgia and National network rate for:

- A member visit to a physician’s office. There is a \$20 office visit co-payment. The \$20 office visit co-payment ***does not include*** any covered charges associated with medical treatment/services;
- Wellness care/preventive healthcare. The maximum wellness benefit that a covered member may receive, when using Georgia and/or National Network providers, is \$750 per person per plan year. There is a \$20 office visit co-payment;
- Second surgical opinions for elective surgery. There is a \$20 office visit co-payment; and
- Allergy shots and serum. If a physician is seen, the visit will be treated as an office visit and will be subject to a \$20 member co-payment.

PHYSICIAN SERVICES PROVIDED IN AN OFFICE SETTING

Georgia In-Network - 90%

National In-Network - 80%

After meeting your deductible, the plan will pay for 90% of the Georgia Network contracted rates; or, for 80% of the National Network contracted rates for:

- Medical treatment/services provided by a physician in an office setting. There is a \$20 office visit co-payment;
- Laboratory charges, including x-rays and diagnostic testing/examinations (exclusive of wellness care/preventive health care);
- Maternity care (prenatal and postnatal). There is an initial \$20 office visit co-payment;
- Diagnostic testing and non-surgical treatment of temporomandibular joint disorders (TMJ);
- Outpatient surgery;
- The removal of impacted teeth, other than partially erupted teeth. There is a \$20 office visit co-payment; and
- Allergy testing.

PHYSICIAN SERVICES PROVIDED IN AN OFFICE SETTING
Out-of-Network - 60%

After meeting your deductible, the plan will pay for 60% of the network rate for: *(Please be reminded that you will be subject to balance billing.)*

- *There will be no plan benefits paid for wellness care/preventive healthcare services rendered by an out-of-network provider. Such charges will not apply to a member's annual deductible or to a member's annual out-of-pocket maximum.*
- Medical treatment/services provided by a physician in an office setting;
- Laboratory charges, including x-rays and diagnostic testing/examinations (exclusive of wellness care/preventive health care);
- Maternity care (prenatal and postnatal);
- Allergy testing, allergy shots, and serum;
- Diagnostic testing and non-surgical treatment of temporomandibular joint disorders (TMJ);
- Removal of impacted teeth, other than partially erupted teeth;
- Second surgical opinions for elective surgery; and
- Outpatient surgery.

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

BCBSGa has been chosen as the administrator of the Behavioral Health Services (BHS) program for the PPO/PPO Consumer Choice healthcare plan. The Behavioral Health Services program provides benefits coverage for mental health and substance abuse treatment services. BCBSGa provides a national network of healthcare professionals and hospitals. Licensed healthcare professionals are available 24-hours a day, 7 days a week, to provide referrals for mental health and substance abuse treatment.

To access information regarding member benefits; please contact BCBSGa at 1-800-292-2879. A Behavioral Health Services care manager will talk with the member; assess the member's condition; and discuss available treatment options. The member's care manager will guide the member in choosing a provider from among those that participate in the network. The care manager will authorize initial treatment for the member.

PLEASE NOTE:

Please contact **BCBSGa at 1-800-292-2879**, to determine if pre-certification is required. Failure to pre-certify when required, will result in a reduced level of benefit coverage or no benefit coverage.

INPATIENT CARE

If a member is admitted to a BCBSGa hospital/facility, a care manager will authorize an initial number of days of treatment. During the member's stay in the hospital, the care manager will review the member's treatment plan with his/her attending physician and with his/her hospital. The care manager may authorize additional hospital/facility days if the member's condition is deemed to be medically necessary. The criteria for establishing medical necessity will be determined by BCBSGa.

▪ ***In-Network Facility Charges:***

After a member meets his/her plan deductible, the plan will pay 90% of the network rate for inpatient treatment and services. The maximum benefit, for services rendered in an inpatient facility, is 60 combined mental health and substance abuse days per person per plan year.

▪ ***In-Network Provider Charges:***

After a member meets his/her plan deductible, the plan will pay 80% of the network rate for inpatient treatment and services. The maximum number of visits/consultations that may be rendered by a network provider, at an inpatient facility, is limited to 60 per person per plan year.

▪ ***Out-of-Network Facility Charges:***

After a member meets his/her plan deductible, the plan will pay 60% of the network rate for inpatient treatment and services. The maximum benefit, for services rendered in an inpatient facility, is 60 combined mental health and substance abuse days per person per plan year. ***Pre-certification is required.***

- **Out-of-Network Provider Charges:**

After a member meets his/her plan deductible, the plan will pay 50% of the network rate for inpatient treatment and services. The maximum number of visits/consultations that may be rendered by a non-network provider, at an inpatient facility, is limited to 25 per person per plan year.

- **Substance Abuse Lifetime Limit:**

Inpatient treatment for substance abuse is limited to 3 episodes per lifetime.

PARTIAL/DAY HOSPITALIZATION AND INTENSIVE OUTPATIENT TREATMENT

After a member meets his/her plan deductible, the plan will pay 90% of the network rate for partial/day hospitalization and intensive outpatient treatment. The maximum benefit for partial/day hospitalization and intensive outpatient services is 30 combined visits/days per person per plan year. ***Benefit coverage is available only at BCBSGa in-network facilities.***

OUTPATIENT CARE

The maximum benefit for outpatient services rendered by a licensed healthcare provider is 50 combined mental health, substance abuse, and brief-therapy visits per person per plan year. The licensed healthcare provider must be credentialed by BCBSGa.

- **In-Network Provider Charges:**

After a member meets his/her plan deductible, the plan will pay 80% of the network rate for outpatient treatment or services. The maximum number of visits/consultations that may be rendered by a network provider is limited to 50 per person per plan year.

Mental health and substance abuse treatment services must be medically necessary and must be provided by a qualified professional. A qualified professional is a licensed Psychiatrist (MD); a licensed Clinical Psychologist (Ph.D.); a licensed Clinical Social Worker (LCSW); a licensed Professional Counselor (LPC); a licensed Marriage and Family Therapist (LMFT); and/or a Masters-level RN (Clinical Nurse Specialist).

- **Out-of-Network Provider Charges:**

After a member meets his/her plan deductible, the plan will pay 50% of the network rate for outpatient treatment or services. The maximum number of visits/consultations that may be rendered by a non-network provider is limited to 25 per person per plan year.

Plan coverage and plan benefits for non-network providers are limited to services/treatments rendered by a Psychiatrist with his/her MD license, **or** by a Psychologist with his/her Ph.D. license degree. There are no benefits for non-network Masters-level healthcare providers.

- **Brief-therapy Annual Limits:**

The Behavioral Health Services plan will pay 100% of the network rate for brief-therapy treatment. Three of the 50 combined mental health and substance abuse visits may be used for brief-therapy consultations. A brief-therapy visit is defined as a form of situational counseling, typically lasting 30 minutes or less. ***BCBSGa network provider must conduct the brief-therapy sessions. Pre-certification is required.***

PLEASE NOTE:

The University System of Georgia PPO/PPO Consumer Choice healthcare plan does not have the legal authority to intervene when a non-participating provider balance bills the member. Therefore, the healthcare plan cannot reduce or eliminate balance billed amounts. The healthcare plan will not make additional payments above the plan allowed benefit limits.

EXPENSES THAT THE MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PLAN DOES NOT COVER (Exclusions)

Some treatment/services that are not covered by the *Mental Health and Substance Abuse* Program include, but are not limited, to:

- Those for hypnotherapy;
- Those for child, career, social adjustment, financial, pastoral or marriage counseling;
- Those for psychological testing unrelated to a behavioral diagnosis;
- Treatment for attention-deficit disorder (ADD) or attention-deficit hyper-disorder (ADHD) therapy (except diagnosis and medical management), learning disabilities, developmental delays, or speech disorders;
- Those for educational examinations or neurolinguistical programming;
- Those for court-ordered mental health and substance abuse treatments, unless medical necessity is certified by BCBSGa;
- Those for situational counseling, other than for brief-visit therapy;
- Those for mental health services, substance abuse services, and eating disorders provided in a residential treatment center (RTC);
- Those for vocational or educational training/services; and
- Those for treatment of a condition that arises from mental retardation, academic-skills disorder, developmental disorder, or motor-skills disorder.

PHARMACY BENEFIT MANAGEMENT (PBM) PROGRAM

Medco has been chosen to administer the prescription drug benefit program for the self-insured healthcare plans of the University System of Georgia. The prescription drug benefit program was designed to offer clinical effectiveness, choice and flexibility. The pharmacy benefit plan was developed after extensive review, analyses, and recommendations of a national panel of physicians and pharmacists.

The University System of Georgia has implemented a three-tiered pharmacy benefit plan. Your three-tiered pharmacy plan includes generic drugs, preferred brand name drugs, and non-preferred brand name drugs. Each tier has its own individual co-payment. Your co-payment will vary based on the specific medication that you and your physician select. The use of generic prescription medications, whenever available, is the most cost effective option for a member.

PRESCRIPTION DRUG CO-PAYMENTS	
Co-Payment For	Participating Retail Pharmacy 30-Day Supply
Generic Drugs	\$10.00
Preferred Brand Name Drugs	\$25.00
Non-Preferred Brand Name Drugs	20% with a \$40.00 minimum and a \$100.00 maximum

- If the usual and customary charge for a generic or preferred brand name drug is less than the copayment amount, the member will pay the lesser of the two.
- If a physician indicates “Brand Necessary” on a prescription, then only a preferred or nonpreferred brand name medication can be dispensed. The member will be responsible for the preferred/nonpreferred brand name medication copayment.
- If a physician does not indicate “Brand Necessary” and the member chooses a preferred/nonpreferred brand name medication over its available generic equivalent, the member will be required to pay the generic copayment.
- In addition to paying the generic copayment, the member will also be responsible for paying the difference in the cost between the generic and the preferred/nonpreferred brand name drug. This difference in member cost is sometimes referred to as an “ancillary charge.”

Days Supply

One co-payment for up to a 30-day supply.

Maintenance Medications

Maintenance medications are those prescription drugs that a member may obtain for a period of up to 90 days. The member will be charged one copayment for each supply of medication up to a 30-day supply.

Other Coverage Rules

For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/ tablets of medication per prescription.

Your PPO/PPO Consumer Choice healthcare plan includes a quarterly out-of-pocket maximum for members who obtain *generic* and *preferred brand name* prescription medications. The copayments for these prescription medications will apply toward your quarterly out-of-pocket maximum. The following quarterly out-of-pocket maximum amounts (stop loss) will apply:

QUARTERLY OUT-OF-POCKET MAXIMUMS	
Employee	\$450 per quarter
Employee + Child (2 covered members)	\$900 per quarter
Employee + Spouse (2 covered members)	\$900 per quarter
Family (3 or more covered dependents)	\$1,350 per quarter

Upon a member reaching his/her quarterly out-of-pocket maximum, his/her prescription drug co-payments will be waived for any additional generic and preferred brand name medications for the remainder of that quarter. Member co-payments will resume at the beginning of the next calendar quarter and will be charged until the plan thresholds are reached for that quarter.

A quarter will consist of three consecutive months as designated below:

1st Quarter - January through March
 2nd Quarter - April through June
 3rd Quarter - July through September
 4th Quarter - October through December

- Co-payments for non-preferred brand name medications will not apply to the quarterly out-of-pocket maximum benefit.
- Prescription drug co-payments do not apply to University System of Georgia medical annual deductible or to medical maximum annual out-of-pocket limits (stop loss).
- If a member purchases a preferred brand name prescription drug that is not indicated as “*Brand Necessary*”, and there is a generic alternative available; only the \$10 generic member co-payment will be applied to the quarterly maximum out-of-pocket member benefit. The difference in cost between the generic alternative and the preferred brand name medication will not apply to the quarterly maximum out-of-pocket member pharmacy benefit.
- Prescription drug co-payments covered by the healthcare plan will not be changed or overridden on an individual basis.

Coverage Management Program

Medco pharmacists, along with physicians, have developed a Coverage Management Program. This program is a prescription drug protocol management resource that promotes the utilization of first-line medications and/or therapeutic categories. Under this program, your plan will usually cover a proven, less expensive medication that is known to be safe and effective, as an initial treatment strategy. If the initial covered medication(s) does not work for you, you or your physician may request a review to obtain coverage for an alternate treatment strategy. A coverage review or “prior authorization” may be required before a member is approved for

coverage of a new prescription drug medication. This review is necessary to determine how your prescription drug plan may cover certain medications.

Coverage Reviews/Prior Authorization

Some medications are not covered unless you receive approval through a coverage review (prior authorization). This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective. There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses) unless you receive approval through a review. During this review, Medco asks your doctor for more information than what is on the prescription before the medication may be covered under your plan. Network pharmacists and physicians have been advised that the University System of Georgia will participate in this program. If you should go to a pharmacy and you are informed that your prescription cannot be filled because it requires a prior authorization, please have your physician contact Medco to complete the coverage review.

Other Coverage Rules

For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/ tablets of medication per prescription.

EXPENSES THE PPO/PPO CONSUMER CHOICE HEALTHCARE PLAN DOES NOT COVER (Exclusions)

Some of the medical services, supplies, or treatments, that are not covered by the PPO/PPO Consumer Choice healthcare plan include, but are not limited to:

- Those that exceed the Georgia Network, the National Network, or the Behavioral Health Services, contracted network rates for covered charges;
- Those that are not medically necessary;
- Those that are provided by an immediate family member or household resident;
- Those that could have been provided in a more cost-effective manner, without affecting the patient's good health. (Example: Incurring hospital charges for a Friday or Saturday inpatient hospital admission, unless the weekend admission was deemed medically necessary by BCBSGa);
- Those that are not recommended/approved by an attending physician;
- Those that were received prior to being eligible for plan participation and coverage;
- Those that may be covered by state or federal programs, such as items covered by Workers' Compensation or Medicare;
- Those charges incurred by a member from his/her for physician, for failure to keep a scheduled appointment;

- Those that are for the medical/surgical management of weight loss *or* for gastric-restrictive procedures associated with the correction of obesity;
- Those that are for fitness/exercise programs;
- Those that are to correct a speech deficiency or to improve a habitual speech disorder;
- Those that are associated with cosmetic surgery, except for charges related to accidental injury, corrective surgery for congenital anomalies, and/or reconstructive surgeries following a mastectomy;
- Those for hair transplants, hair pieces or wigs;
- Those for hearing aids;
- Those for foot orthotics and/or foot inserts;
- Those that are incurred, directly or indirectly, from participating in an insurrection, a war, or the service in the armed forces of any country;
- Those that are custodial in nature;
- Those that are investigational/experimental in nature;
- Those for infertility drugs or artificial insemination agents;
- Those for a sex transformation;
- Those associated with any type of infertility treatment/procedures or testing; including, but not limited to, artificial insemination, invitro-fertilization, embryo transfer processes, and/or reversal sterilization;
- Those for the treatment of sexual dysfunction or inadequacies, including the treatment for impotency (except male organic erectile dysfunction);
- Those for acupuncture therapy;
- Those that are not provided by a legally licensed physician. The medical services and/or treatment provided must be within the scope of the physician's license;
- Those for nutritional supplements, unless sole source of nutrition (prior approval required);
- Those for smoking cessation programs (unless approval received through the Last Cigarette Program) (TLC)
- Those for dental work, dental X-rays, implants or dentures, periodontal and osseous surgery unless the procedure results from accidental injury to natural teeth sustained while covered under the plan; and

- Those for radial keratotomy; and/or for the surgical correction of nearsightedness, astigmatism, or any other correction of vision due to a refractive problem.

WHEN YOUR PPO/PPO CONSUMER CHOICE HEALTHCARE PLAN COVERAGE ENDS

Your coverage, under the PPO/PPO Consumer Choice healthcare plan, will end on the last day of the month in which:

- You are no longer eligible to participate in the plan;
- You elect to withdraw from the plan during an open enrollment period;
- Your employment is terminated, except due to death;
- You fail to make any required employee contribution; or
- The PPO/PPO Consumer Choice healthcare plan is terminated.

Please be reminded that you may continue with your coverage under the PPO/PPO Consumer Choice healthcare plan, if you are on a campus-approved leave of absence.

Blue Cross Blue Shield of Georgia will issue a *Certificate of Creditable Coverage* to a member when his/her PPO/PPO Consumer Choice healthcare plan coverage ends. This Certificate of Creditable Coverage may be presented to a new employer to demonstrate proof of previous healthcare plan coverage. The BCBSGA Certificate of Creditable Coverage affords compliance with specific provisions of the federal Health Insurance Portability and Accountability Act (HIPAA).

WHEN PPO/PPO CONSUMER CHOICE HEALTHCARE PLAN COVERAGE FOR YOUR ELIGIBLE AND COVERED DEPENDENT(S) ENDS

Your PPO/PPO Consumer Choice healthcare plan provides coverage for full-time student dependent until he/she attains age 26. *On a dependent's 26th birthday*, his/her healthcare coverage will terminate. Healthcare coverage extended to your eligible and covered dependents (other than full-time students) will end on the last day of the month in which:

- Your dependent(s) ceases to be eligible;
- Your dependent(s) becomes eligible for coverage under the plan, as a University System of Georgia employee;
- You are no longer eligible to participate in the plan;
- You elect to withdraw from the plan during an open enrollment period;
- Your employment is terminated;
- You elect to reduce your level of benefit coverage: (1) from “*family*” coverage to “*employee + child*” or “*employee + spouse*” coverage or to “*single*” coverage; or (2) from “*employee + child*” or “*employee + spouse*” coverage to “*single*” coverage;
- You fail to make any required employee contribution; or
- The plan is terminated.

If your PPO/PPO Consumer Choice healthcare plan coverage ends, you and/or your dependents may be eligible for an extension of coverage under the special provisions of the plan. Please see the section entitled, “*Coverage After Retirement*”, located on the next page, or the section entitled, “*Extended Coverage for Your Dependents After Your Death*”, located on page 66 of this booklet.

COVERAGE FOR ACTIVE EMPLOYEES AGE 65 OR OVER

If a member continues to work past the age of 65, he/she may be eligible to access healthcare coverage under the PPO/PPO Consumer Choice healthcare plan and under Medicare Part A. If a member meets the eligibility requirements for participation in Medicare Part A, he/she should apply for these benefits with Social Security.

For an active employee who is age 65 and older, the PPO/PPO Consumer Choice plan will continue to provide primary healthcare coverage. If the member has enrolled in Medicare Part A, secondary healthcare coverage may be available under Medicare.

If an employee has a spouse who is age 65 or older, the spouse should apply for Medicare Part A and Part B, when eligible.

COVERAGE AFTER RETIREMENT

When a member retires from active service with the University System of Georgia, participation in the PPO/PPO Consumer Choice healthcare plan may be continued into retirement if the member complies with the requirements as prescribed by the Board of Regents *Policy Manual*. A member who enters retirement may continue with the same level (single, employee + child, employee + spouse, or family) of healthcare coverage that he/she had immediately prior to retirement. On page 24 of this booklet, information is provided regarding the *University System of Georgia Retiree Annual Change Period*.

Continued participation in the healthcare plan is voluntary. You will continue to pay your employee portion of the monthly premium. The institution from which you retired will continue to pay the employer's share of your monthly premium.

The costs of healthcare plan premiums for employees, retirees and dependents of the University System of Georgia changes periodically. Your campus Human Resources/Personnel Office will notify you of any changes in plan costs and in employer/employee contribution rates.

If you carry "employee + child" or "employee + spouse" healthcare coverage or "family" healthcare coverage into retirement, and you predecease your spouse, your covered dependents will be permitted to continue their healthcare coverage.

Healthcare coverage for the spouse will continue until his/her death or remarriage. Coverage for dependent children would continue until they ceased to be eligible.

When a retired member of the University System of Georgia reaches age 65, it is strongly recommended that he/she apply for Medicare Part A and Part B. If a member meets the eligibility requirements for participation under both Medicare Part A and B, he/she should apply for these benefits with Social Security. If you are covered by both Medicare and the PPO/PPO Consumer Choice healthcare plan, your Medicare coverage will be primary. Your PPO/PPO Consumer Choice plan coverage will be secondary.

If an employee has a spouse who is age 65 or older, the spouse should apply for Medicare Part A and Part B, when eligible.

The University System of Georgia reserves the right to alter, modify or terminate these retiree healthcare benefits at any time and from time to time. Nothing in the Plan entitles retirees to lifetime healthcare benefits from the University System of Georgia.

EXTENDED HEALTHCARE COVERAGE FOR DEPENDENTS AFTER THE DEATH OF A COVERED EMPLOYEE

(A) Deceased University System of Georgia Employee With A Minimum of Ten Years of Service

A dependent, of an active employee who dies while in active service or in retirement, may remain as a participant of the PPO/PPO Consumer Choice healthcare plan under the following conditions:

- The deceased employee must have had at least ten years of continuous service in a benefits eligible position with the University System of Georgia; *or*

- The deceased employee must have had ten years of continuous service with the State of Georgia. The final two years of State of Georgia continuous service must have been with the University System of Georgia in a benefits eligible position.

The University System of Georgia will continue to pay the employer portion of healthcare plan premiums until the dependent ceases to be eligible. Healthcare coverage for a deceased member's spouse will continue until his/her death or remarriage.

(B) Deceased University System of Georgia Employee With Less Than Ten Years of Service

A dependent, of an active employee who dies with less than ten years of service, may remain as a participant in the PPO/PPO Consumer Choice healthcare plan for no more than 12 consecutive months after the death of the employee. The University System of Georgia will pay the employer portion of the healthcare plan premiums for this 12 month period. After this 12-month period, a dependent may elect to continue his/her healthcare coverage through COBRA. However, the COBRA coverage period to which the dependent may be entitled due to the death of the employee will be reduced by this 12-month period of coverage. However, the COBRA coverage period to which the dependent may be entitled due to the death of the employee will be reduced by this 12-month period of coverage. For information regarding ***Your COBRA Rights***, please see page 74 of this booklet.

FILING PAPER CLAIMS/USE OF PHYSICIAN WHO IS NOT A PROVIDER WITHIN THE NETWORK

If you receive medical care from a physician who is not a member of the Georgia network or the National PPO/PPO healthcare network, you will have ***one year*** from the date that such service was rendered to file a paper claim and receive reimbursement for covered charges.

Claims should be submitted to:

Blue Cross Blue Shield of Georgia
Post Office Box 7728
Columbus, GA 31908-7728
Telephone: 1-800-424-8950/TDD 404-842-8073

GENERAL INFORMATION REQUIRED TO FILE A CLAIM

In order to process your medical claim, the following information is required regardless of the provider. Plan benefits will be paid upon receipt of: (1) a completed claim form; and (2) provider documentation of medical treatment and/or services. The claim form must be filled out in its entirety. Any missing information may cause a delay in processing your reimbursement. The following information must be included on the claim form:

- Name of the contract holder; contract number; and group number, exactly as it appears on your member identification card;
- Provider documentation of medical treatment/services and detailed diagnosis; and

- A copy of the provider's billing statement indicating:
 - The name of the patient;
 - The type of treatment or services rendered;
 - The date and charges for treatment or services;
 - The signature of the provider; and
 - Provider tax ID # and physical address.

Please retain a copy of all claim forms and bills for your records.

Claims forms are available and may be obtained from your campus Human Resources/Personnel Office, from the BCBSGA Customer Service department, or via electronic format from the University System of Georgia website at: www.usg.edu/employment/benefits/health/ or the BCBSGa website at www.bcbsga.com.

PLEASE NOTE:

The following *do not meet* the supporting documentation requirements for filing a paper claim: (1) a provider billing statement that reflects a "balance due" amount; (2) a cash receipt issued to a member from a provider; and/or (3) a canceled check reflecting a member's payment for provider services.

FILING PAPER CLAIMS/FOREIGN CLAIMS WHILE TRAVELING ABROAD

If a member receives medical care while traveling outside of the United States, he/she will be required to pay the provider at the time that medical services are rendered. The member will have *one year* from the date that the medical services were rendered to file a paper claim and receive reimbursement for covered charges.

Claims should be submitted to:
BlueCard Worldwide® Service Center
P O Box 72017
Richmond, VA 23255-2017 USA

For inpatient care at a BlueCard Worldwide® hospital that was arranged through the BlueCard Worldwide Service Center, call 1-800-810-BLUE (2583), you only pay the provider the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance). The provider files the claim for you.

For all outpatient and professional medical care, you pay the provider and submit a claim. You may also have to pay the hospital (and submit a claim) for inpatient care obtained from a non-BlueCard Worldwide® hospital or when inpatient care was not arranged through the BlueCard Worldwide Service Center.

To submit a claim, you complete an International Claim Form and send it to the BlueCard Worldwide Service Center. The claim form must be completed fully otherwise it will be returned to you and payment will be delayed.

For questions, you may contact your local BCBSGa Customer Service Unit or the BlueCard Worldwide Service Center Outside the U.S. (call collect): 1-800-673-1177.

Plan benefits will be paid upon receipt of: (1) a completed claim form; and (2) an itemized bill for medical treatment and/or services. The member will be required to have the itemized bill translated into English *prior to* submitting a paper claim to BCBSGA. To expedite the processing of such claims, BCBSGA requests that the billed amount be converted to an equivalent United States currency rate.

The claim form must be filled out in its entirety. Any missing information may cause a delay in processing your reimbursement.

All foreign pharmacy claims must be submitted directly to BCBSGa.

PLEASE NOTE:

An explanation of benefit (EOB) form and reimbursement for covered medical treatment/services will be mailed to a member's United States mailing address. BCBSGA ***will not*** mail this type of information to any address outside the United States.

Please be reminded that the member must pay for provider services rendered outside of the United States. BCBSGA ***will not*** reimburse a non-United States healthcare provider.

DENIAL OF A CLAIM BY BCBSGA

If you have a medical claim that is denied, you will receive written notification from BCBSGA. The denial notice will include:

- The specific reason(s) for the denial;
- A reference to the plan provision(s) that supports the denial by BCBSGA;
- The clarification of information required from the member/provider to complete the processing of the claim; and
- An explanation regarding the necessity for providing additional information.

If a time extension to process a claim is required by BCBSGA, you will be notified in writing and provided with an explanation for the reason for the extension.

APPEALING A DENIED CLAIM

A member has a right to express concerns about a denied claim and to expect an unbiased resolution of his/her issues. BCBSGA is an important informational resource that should be initially contacted to answer member inquiries and to confirm the types of coverage that have been adopted and implemented for the PPO/PPO Consumer Choice healthcare plan.

If a medical claim is denied, the member may appeal this decision to BCBSGA ***within 60 days*** of the date that the claim was denied.

Please contact the BCBSGA Customer Service department at 1-800-424-8950/TDD 404-842-8073. Please share your concerns regarding a denied medical claim with the BCBSGA customer service representative.

When discussing a claim, please provide the following information:

- Contract holder name and identification number;
- Patient name and address;
- Provider name and address (hospital and/or physician);
- Date/dates of service; and
- Type of service received.

You have the right to submit a written inquiry regarding your denied medical claim. Written inquiries should be directed to:

Blue Cross Blue Shield of Georgia
Post Office Box 7728
Columbus, GA 31908-7728

You should receive a written response from BCBSGA regarding your initial written inquiry *within 30 calendar days*.

Following the review process by BCBSGA, a member may submit a final appeal to the plan administrator. The plan administrator will not accept any member appeal until the entire BCBSGA process has been completed. The member will be required to provide the plan administrator with all supporting documentation presented at the respective levels of the BCBSGA appeal process. The plan administrator will render a final decision.

APPEALING A DENIED Precertification

Please contact BCBSGa at 1 (800)233-5765 to request an appeal on a denied precertification. Request may be made by the member or physician.

ASSIGNMENT OF BENEFITS

The process for the assignment of benefits permits a member to have his/her plan benefits paid directly to a provider (physician/hospital) for medical treatment/services that have been rendered. Healthcare benefits are automatically paid to:

- Physicians, hospitals, and ancillary providers that are providers in the Georgia Network; Physicians, hospitals, and ancillary providers that are providers in the National Network;
- Mental health providers in the BCBSGa network; and
- Centers of Expertise for the *Organ and Tissue Transplant* program.

SUBROGATION AND RIGHT OF REIMBURSEMENT

Summary. The Plan includes a subrogation clause. This means that BCBSGA may not be obligated to pay any medical benefits to a covered member or it may recover any benefits paid to a covered member for an injury or illness involving alleged negligence or misconduct of a third party. If a covered member has or could assert a claim against any third party for payment of his or her medical bills, then any payment by the Plan for such benefits will be made only on the condition that the covered member will reimburse the Plan to the extent of the amount received from the third party. Alternatively, BCBSGA may seek recovery from the third party. The covered member will be responsible for providing BCBSGA with any information or assistance needed to enforce this provision.

Subrogation Agreement. Before any benefits are paid to a covered member for any injury or illness for which a third party is or may be responsible, the covered member may be required to execute a written subrogation and reimbursement agreement. The covered member will acknowledge the Plan's subrogation interest, agree to repay any claims paid by the Plan, pledge and assign any recovery as security for repayment of any claims paid by the Plan, and assign all third party claims to the Plan. A covered member's failure or refusal to sign this agreement shall in no way impair, waive, or modify the Plan's subrogation and reimbursement rights. If a covered member does not execute and/or deliver such agreement or any other information reasonably requested by the Plan, the Plan may withhold any benefits to the covered member.

Notice. The covered member must notify the Plan in writing within five business days of the beginning of any proceeding relating to a third party claim, and must submit a copy of the complaint or other pleadings filed in the third party claim. The covered member must notify the Plan within two business days of any recovery from a third party.

Recovery Amount. The Plan has a right to recover an amount equal to the smaller of:

1. the benefits actually paid or due under the Plan to the covered member relating to the illness or injury, or
2. the recovery received, no matter whether the recovery is for actual or punitive damages, costs or expenses, medical expenses, pain and suffering, lost wages, workers' compensation, disability payments, loss of consortium, loss of work payments, emotional distress, or otherwise.

The Plan has the right to first recovery, and the "make whole" doctrine is not applicable to the Plan's subrogation and reimbursement rights. The Plan has the right of first reimbursement for all benefits paid related to the illness or injury.

Fees and Costs. All fees and expenses incurred by the covered member, including but not limited to attorney fees and court costs, are the responsibility of the covered member, not the Plan. Accordingly, the amount to be reimbursed to the Plan shall not be reduced by any portion of such amounts. However, the Plan may allow a reduction of the amount equal to its proportionate share of attorney's fees and court costs where the covered member and his or her attorney cooperate with the Plan in enforcement of the Plan's subrogation and reimbursement rights.

If the covered member fails to repay the Plan from any recovery, the covered member is liable for all costs of collection, including the Plan's attorneys' fees and expenses. As a means of collecting the amounts owed, the Plan may set-off future benefits to the covered member. In addition, the Plan shall have a lien against any recovery and against future health benefits due under the Plan in the amount of any claims paid by the Plan relating to the illness or injury, plus all costs of collection (if any) due the Plan.

ADMINISTRATIVE INFORMATION

COORDINATION OF BENEFITS (COB)

A number of healthcare plan members and enrolled dependents may be covered under another healthcare plan that provides medical benefits on a group-insurance basis. If you are such a member, you should be informed about the PPO/PPO Consumer Choice plan's provision for "Coordination of Benefits (COB)". The plan member is responsible for notifying BCBSGa of any COB changes.

The PPO/PPO Consumer Choice plan's (COB) provision stipulates that, when there is multiple coverage by two or more group-insurance medical benefit plans, reimbursement by the Board of Regents PPO/PPO Consumer Choice plan will not exceed 100% of the covered charges incurred. Covered charges do not include member penalties assessed for plan non-compliance.

The COB provision applies to any group-insurance medical benefit plan. Examples would include governmental programs, such as Medicare; or the employer of a spouse who offers group-insurance medical benefits. COB does not apply to an individual policy for healthcare coverage, for which the member pays the total premium directly to the insurer.

To administer the COB provision, it must be determined which group-insurance medical plan is deemed to have "primary" coverage. The primary plan will be required to initially process and pay any covered medical claims. This generally means that the primary plan will pay for the majority of the costs associated with such claims. Any other group-insurance medical plan(s) is deemed to have "secondary" coverage responsibilities.

The decision, regarding which group-insurance medical plan is "primary", is made as follows:

1. A plan without a Coordination of Benefits (COB) provision is primary over a plan with COB provision.
2. A group-insurance medical plan that covers an individual as an active or retired employee is primary over a group-insurance medical plan that covers an individual as a dependent.

An *exception* to this policy is:

An institution has a retiree of the University System of Georgia (USG). The USG retiree has healthcare coverage with: (1) the University System of Georgia; (2) Medicare; and (3) is covered as a dependent under his/her spouse's active group healthcare plan. In this case, the spouse's healthcare plan coverage is primary; Medicare coverage is secondary; and the retiree's USG healthcare plan has the third or tertiary level of responsibility.

3. For *children*, the healthcare plan of the parent whose birthday occurs earlier in the calendar year is deemed to be primary. If both parents' birthdays occur on the same day, the healthcare plan that has insured the parent for the longest period of time is primary. If one of the plans does not have the parent birthday rule, the father's healthcare plan is primary.
4. For children of separated or divorced parents:
 - (A) When a *court decree has determined that one parent has financial responsibility* for medical, dental or other healthcare expenses of a child, the healthcare plan of the parent with court-decreed financial responsibility is primary to any other plan covering the child (regardless of which parent has custody).
 - (B) When a *court decree states that the parents will share joint custody*, without specifying which parent has financial responsibilities for medical or dental care expenses of a child, the plan providing primary coverage for the child, will follow the sequence of benefit determination rules presented below:
 1. The healthcare plan of the parent whose birthday occurs earlier in the calendar year is primary;

2. When both parents' birthdays occurs on the same day, the healthcare plan that has insured the parent for the longest period of time is primary; and
3. If one of the plans does not have the parent birthday rule, the father's healthcare plan is primary.

(C) In the *absence of court-decreed financial responsibility*:

3. For healthcare plans that cover a *child of separated or divorced parents who have not remarried*, the healthcare plan of the parent with custody is deemed to be primary.
4. For healthcare plans that cover a *child of remarried parent(s)*:
 - The healthcare plan of the remarried parent, with custody, is deemed to be primary;
 - The healthcare plan of the step-parent is deemed to be secondary; and
 - The healthcare plan of the biological parent, without custody, is deemed to have the third level of healthcare payment responsibility.
5. The healthcare plan that covers an insured individual as an active employee is primary over a healthcare plan that covers a retiree or laid-off employee. The same process is true for an active employee covered by his/her employer's group-insurance medical plan who is also covered as a dependent under a retiree's/laid-off employee's group-insurance medical plan. An active employee's healthcare plan will have primary coverage responsibilities.

Benefits under the Board of Regents PPO/PPO Consumer Choice healthcare plan will also be coordinated with benefits provided by the federal Medicare program. If a member has both USG PPO/PPO Consumer Choice healthcare coverage and Medicare coverage, COB procedures will be established as follows:

- If you are covered under the PPO/PPO Consumer Choice healthcare plan as an active employee or as the spouse of an active employee, the USG PPO/PPO Consumer Choice plan will be primary.

Your network provider will file medical claims with the USG PPO/PPO Consumer Choice plan initially and then, with Medicare. In many cases, your healthcare provider will file your medical claims with the USG PPO/PPO Consumer Choice healthcare plan and Medicare simultaneously.

- If you are covered under the USG PPO/PPO Consumer Choice healthcare plan as a retiree or as the spouse of a USG retiree, and you are age 65 or older, Medicare will be primary.

If you return to active employment with another employer after you reach age 65 and you are covered by the new employer's group-insurance healthcare plan, then: (1) your new employer's healthcare plan will be primary; (2) Medicare coverage will be secondary; and (3) the USG healthcare plan will be considered to have a third or tertiary coverage responsibilities.

YOUR COBRA RIGHTS

Summary. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) you or your covered dependents have the option of continuing healthcare coverage under the Plan when you or your covered dependents would otherwise lose coverage. Terms, conditions, and costs for healthcare coverage are identified below. If your coverage is continued under COBRA, BCBSGa must continue to review and approve all medical treatment/services that are provided for you and your covered dependents. You will be required to comply with all Plan requirements to receive covered benefits.

What is COBRA Coverage? COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event”. Qualifying events are listed below. After a qualifying event occurs, and any required notice is properly given, COBRA coverage must be offered to each person losing coverage who is a “qualified beneficiary”. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Each qualified beneficiary has the right to continue the level of coverage in effect on the day before the qualifying event (or a lesser level of coverage). Under the Plan, qualified beneficiaries who elect COBRA must pay for the COBRA coverage.

You may elect COBRA coverage if any of the following qualifying events occur:

- Coverage for you and your covered dependents can be continued for up to 18 months if:
 - You terminate your employment with the University System of Georgia, for reasons other than gross misconduct; or
 - You have a reduction in your work commitment to less than half time. To be eligible for benefits coverage, you must be employed by the University System of Georgia for at least 20 hours per week on a regular basis.
- There are changes in family circumstances that would permit a covered dependent to extend his/her COBRA coverage from an initial 18-month eligibility period up to a maximum of a 36-month eligibility period. Presented below are the conditions that would permit this extension of COBRA healthcare coverage for up to 36 months.
 - Coverage may be provided for your spouse and dependents, if you die;
 - Coverage may be provided for your spouse and dependents, if you legally separate or divorce;
 - Coverage may be provided for your child, when the child is no longer an eligible dependent under the PPO/PPO Consumer Choice healthcare plan; or,
 - Coverage may be provided for your spouse and dependents when you become Medicare eligible, usually at age 65.
- Under certain conditions, COBRA healthcare coverage may be granted for a period of 29 months:
 - A covered member of your family is disabled at the time of the loss of your healthcare coverage.
- Under certain conditions, COBRA healthcare coverage may be extended from an initial 18-month eligibility period to a 29-month eligibility period:
 - A covered member of your family becomes disabled while you are receiving COBRA healthcare benefits.

Disability Extension of COBRA Coverage. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify your Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. This extension is available only for qualified beneficiaries who are COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the COBRA coverage period that would be available without the disability extension. (Generally 18 months). The disability extension is available only if you notify your Employer in writing of the Social Security Administration's determination of disability within 60 days after the later of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction in hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the covered employee's termination of employment or reduction in hours.

You also must provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. **If notice is not provided during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction in hours, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second Qualifying Event. If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction in hours, the spouse and dependent children receiving COBRA coverage can get up to an additional 18 months of coverage if proper notice of the second event is given to the Plan. The extension for a second qualifying event is available only if you notify the Employer in writing of the second qualifying event within 60 days after the date of the second qualifying event. **If notice is not provided during the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Effect of Entitlement to Medicare. When the qualifying event is termination of employment or reduction in hours and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment ends, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement which is equal to 28 months after the date of the qualifying event (36 months less 8 months). The COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before termination of employment or reduction in hours.

Electing COBRA. Qualified beneficiaries entitled to COBRA coverage have 60 days from the date of notice from the Plan to elect COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA. Covered members and spouses may elect COBRA on behalf of all the qualified beneficiaries and parents may elect COBRA on behalf of their children. **ANY QUALIFIED BENEFICIARY FOR WHOM COBRA IS NOT ELECTED WITHIN THE 60 DAY ELECTION PERIOD WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

If the PPO/PPO Consumer Choice healthcare plan continues to provide coverage for any period of time after a COBRA qualifying event occurs, such time will be counted against the 18, 29, or 36 months of COBRA eligibility.

The cost for COBRA healthcare coverage will be the combined employer and employee premium contribution amounts, plus an additional 2% administrative fee. The member cost for COBRA healthcare coverage would, therefore, be 102% of the total indemnity healthcare premiums. The employee/employer premium costs for the indemnity healthcare plan changes periodically. As changes in premiums for the indemnity plan change, costs for COBRA healthcare coverage will change accordingly.

COBRA healthcare premiums must be paid to your campus Human Resources/Personnel Office. A member must make an election for COBRA healthcare coverage within 60 days (after the date of the COBRA continuation notice) of his/her loss of University System of Georgia healthcare coverage.

The member must submit his/her initial premium payment within 45 days of election of COBRA coverage or COBRA healthcare continuation rights will be forfeited. *A member will be required to remit all premiums to his/her institution from the date of his/her initial loss of University System of Georgia healthcare coverage.*

Thereafter, the member will be responsible for remitting monthly premiums to his/her campus Human Resources/Personnel Office, consistent with an institutionally determined schedule of payment.

PLEASE NOTE:

It is the member's responsibility to notify his/her campus Human Resources/Personnel office for all qualifying events other than the end of the covered member's employment or reduction in hours or death of the covered member. For other qualifying events (divorce or legal separation of the covered member and spouse, or a child's losing eligibility for the University System of Georgia healthcare coverage) a COBRA election will be available only if you provide notice in writing within 60 days after the later of (1) the date of the qualifying event and (2) the date on which the qualified beneficiary loses or would lose coverage under the terms of the Plan as a result of the qualifying event. Oral notice, including notice by telephone is not acceptable. If the notice is mailed, it must be postmarked no later than the last of the notice period. **IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE REQUIRED NOTICE IS NOT PROVIDED DURING THE 60 DAY PERIOD, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.**

COBRA healthcare coverage will end prior to the end of the 18-month, 29-month or 36-month maximum eligibility participation period if:

- A COBRA-covered disabled family member who recovers from his/her disability after his/her initial 18-month eligibility period and prior to the conclusion of the 29-month COBRA eligibility period;
- The member fails to remit his/her required COBRA healthcare premium within the institutionally approved schedule for payment;
- The University System of Georgia healthcare plan is terminated;

- After election, a qualified beneficiary becomes covered under another group health plan other than a group health plan which may limit a qualified beneficiary's coverage because it involves a pre-existing condition;
- After election, a qualified beneficiary becomes entitled to receive benefits under Medicare, or
- Termination for cause (e.g., submission of a fraudulent claim).

The qualified beneficiary must notify the Plan within 30 days after he becomes covered by another group health plan or entitled to Medicare.

Other Qualifying Beneficiaries. A child born to, adopted by, or placed for adoption with a covered member during a period of COBRA coverage is considered to be a qualified beneficiary provided that the covered employee is a qualified beneficiary and the covered employee elected COBRA for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment and it lasts for as long as COBRA coverage lasts for the other family members. To be enrolled in the Plan the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMSCOS. A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMSCO) received by the Employer during the covered employee's period of employment is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE OF PRIVACY PRACTICES

The broad mission and extensive scope of operations of the Board of Regents of the University System of Georgia, including the constituent colleges and universities of the University System of Georgia (collectively, the "Board"), necessitates that the Board collect, maintain, and, where necessary, disseminate health information regarding the Board's students, employees, volunteers, and others. For example, the Board collects medical information through its various medical and dental hospitals, clinics, and infirmaries, through the administration of its various medical and life insurance programs, and through its various environmental health and safety programs. The Board protects the confidentiality of individually identifiable health information that is in its possession. Such health information, which is protected from unauthorized disclosure by Board policies and by state and federal law, is referred to as "protected health information," or "PHI."

PHI is defined as any individually identifiable health information regarding an employee's, a student's, or a patient's medical/dental history; mental or physical condition; or medical treatment. Examples of PHI include patient name, address, telephone and/or fax number, electronic mail address, social security number or other patient identification number, date of birth, date of treatment, medical treatment records, medical enrollment records, or medical claims records.

The Board will follow the practices that are described in its Notice of Privacy Practices ("Notice"). The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in conspicuous locations.

Permitted Uses and Disclosures of PHI

The following categories describe the different ways in which the Board may use or disclose your PHI. We include some examples that should help you better understand each category.

The Board may receive, use, or disclose your PHI to administer your health and dental benefits plan. Please be informed that the Board, under certain conditions and circumstances, may use or disclose your PHI *without obtaining your prior written authorization*. An example of this would be when the Board is required to do so by law.

For Treatment. The Board may use and disclose PHI as it relates to the provision, coordination, or management of medical treatment that you receive. The disclosure of PHI may be shared among the respective healthcare providers who are involved with your treatment and medical care. For example, if your primary care physician needs to use/disclose your PHI to a specialist, with whom he/she consults regarding your condition, this would be permitted.

For Payment. The Board may use and disclose PHI to bill and collect payment for healthcare services and items that you receive. The Board may transmit PHI to verify that you are eligible for healthcare and/or dental benefits. The Board may be required to disclose PHI to its business associates, such as its claims processing vendor, to assist in the processing of your health and dental claims. The Board may disclose PHI to other healthcare providers and health plans for the payment of services that are rendered to you or to your covered family members by such providers or health plans.

For Healthcare Operations. The Board may use and disclose PHI as part of its business operations. As an example, the Board may require a healthcare vendor partner (referred to as a “business associate”) to survey and assess constituent satisfaction with healthcare plan design/coverage. Constituent survey results assist the Board in evaluating quality of care issues and in identifying areas for needed healthcare plan improvements. Business associates are required to agree to protect the confidentiality of your individually identifiable health information.

The Board may disclose PHI to ensure compliance with applicable laws. The Board may disclose PHI to healthcare/dental providers and health/dental plans to assist them with their required credentialing and peer review activities. The Board may disclose PHI to assist in the detection of healthcare fraud and abuse. Please be reminded that the lists of examples that are provided are not intended to be either exhaustive, or exclusive.

As Required by Law and Law Enforcement. The Board must disclose PHI when required to do so by applicable law. The Board must disclose PHI when ordered to do so in a judicial or administrative proceeding. The Board must disclose PHI to assist law enforcement personnel with the identification/location of a suspect, fugitive, material witness, or missing person. The Board must disclose PHI to comply with a law enforcement search warrant, a coroner’s request for information during his/her investigation, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. The Board may disclose PHI to government agencies that are responsible for public health activities and to government agencies that are responsible for minimizing exposure to public health risks.

The Board may disclose PHI to government agencies that maintain vital records, such as births and deaths. Additional examples in which the Board may disclose PHI, as it relates to public health activities, include assisting in the prevention and control of disease; reporting incidents of child abuse or neglect; reporting incidents of abuse, neglect, or domestic violence; reporting reactions to medications or product defects; notifying an individual who may have been exposed to a communicable disease; or, notifying an individual who may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities. The Board may disclose PHI to a government agency that is authorized by law to conduct health oversight activities. Examples in which the Board may disclose PHI, as it relates to health oversight activities, include assisting with audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities that are necessary to monitor healthcare systems, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. The Board may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent; for determining a cause of death; or, otherwise as necessary, to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye, and Tissue Donation. The Board may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, the Board may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. The Board may use and disclose PHI to law enforcement personnel or other appropriate persons. The Board may use and disclose PHI to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. The Board may use and disclose PHI for military personnel and veterans, under certain conditions, and if required by the appropriate authorities. The Board may use and disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities.

The Board may use and disclose PHI for the provision of protective services for the President of the United States, other authorized persons, or foreign heads of state. The Board may use and disclose PHI to conduct special investigations.

Workers' Compensation. The Board may disclose PHI for worker's compensation and similar programs. These programs provide benefits for work-related injuries or illnesses.

Appointment Reminders/Health Related Benefits and Services. The Board and/or its business associates may use and disclose your PHI to various other business associates that may contact you to remind you of a healthcare or dental appointment. The Board may use and disclose your PHI to business associates that will inform you of treatment program options, or, of other health related benefits/services such as Condition Care Management Programs.

Disclosures for HIPAA Compliance Investigations. The Board must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when so requested. The Secretary may make such a request of the Board to investigate its compliance with privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures of Your PHI to Which You Have An Opportunity to Object

You have the opportunity to object to certain categories of uses and disclosures of PHI that the Board may make:

Patient Directories. Unless you object, the Board may use some of your PHI to maintain a directory of individuals in its hospitals or provider facilities. This information may include your name, your location in the facility, your general condition (e.g. fair, stable, etc.), and your religious affiliation. Religious affiliation may be disclosed to members of the clergy. Except for religious affiliation, the information that is maintained in a patient directory may be disclosed to other persons who request such information by referring to your name.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, the Board may disclose your PHI to a family member, another relative, a friend, or another person whom you have identified as being involved with your healthcare, or, responsible for the payment of your healthcare. The Board may also notify these individuals concerning your location or condition.

Fundraising Activities. Unless you object, the Board may disclose your PHI to contact you for fundraising efforts to support the Board, its related foundations, and/or its cooperative organizations. Such disclosure would be limited to personal contact information, such as your name, address and telephone number. The money raised in connection with these fundraising activities would be used to expand and support the provision of healthcare and related services to the community.

If you object to the use of your PHI in any, or all, of the three instances identified above, please notify your campus or facility privacy officer, in writing.

Other Uses and Disclosures of Your PHI For Which Authorization Is Required

Certain uses and disclosures of your PHI will be made only with your written authorization. Please be advised that there are some limitations with regard to your right to object to a decision to use or disclose your PHI.

Regulatory Requirements. The Board is required, by law, to maintain the privacy of your PHI, to provide individuals with notice of the Board's legal duties and PHI privacy practices, and to abide by the terms described in this Notice.

The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise its Notice and post a new Notice in conspicuous locations. You have the following rights regarding your PHI:

You may request that the Board restrict the use and disclosure of your PHI. The Board is not required to agree to any restrictions that you request, but if the Board does so, it will be bound by the restrictions to which it agrees, except in emergency situations.

You have the right to request that communications of PHI to you from the Board be made by a particular means or at particular locations. For instance, you might request that communications be made at your work address, or by electronic mail, rather than by regular US postal mail. Your request must be made in writing. Your request must be sent to the privacy officer on your campus or facility. The Board will accommodate your reasonable requests without requiring you to provide a reason for your request.

Generally, you have the right to inspect and copy your PHI that the Board maintains, provided that you make your request in writing to the privacy officer on your campus or your facility. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. In some cases, the Board may provide you with a summary of the PHI that you request, if you agree in advance to a summary of such information and to any associated fees. If you request copies of your PHI, or agree to a summary of your PHI, the Board may impose a reasonable fee to cover copying, postage, and related costs.

If the Board denies access to your PHI, it will explain the basis for the denial. The Board will explain your opportunity to have your request and the denial reviewed by a licensed healthcare professional (who was not involved in the initial denial decision). This healthcare professional will be designated as a reviewing official. If the Board does not maintain the PHI that you request, but it knows where your requested PHI is located; it will advise you how to redirect your request.

If you believe that your PHI maintained by the Board contains an error or needs to be updated, you have the right to request that the Board correct or supplement your PHI.

Your request must be made in writing to the privacy officer on your campus or in your facility. Your written request must explain why you desire an amendment to your PHI.

Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. The Board generally can deny your request, if your request for PHI: (i) is not created by the Board, (ii) is not part of the records the Board maintains, (iii) is not subject to being inspected by you, or (iv) is accurate and complete.

If your request is denied, the Board will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial, (ii) if you do not file a statement of disagreement, to submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the Board's denial attached, and (iii) complain about the denial.

You generally have the right to request and receive a list of the disclosures of your PHI that the Board has made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003).

The list will not include disclosure for which you have provided a written authorization, and will not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations, (ii) made to you, (iii) for the Board's patient directory or to persons involved in your healthcare, (iv) for national security or intelligence purposes, or (v) to correctional institutions or law enforcement officials.

You should submit any such request to the privacy officer on your campus or in your facility. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will respond to you regarding the status of your request. The Board will provide the list to you at no charge. If you, however, make more than one request in a year, you will be charged a fee for each additional request. You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically. This notice may be found at the Board website address, www.usg.edu/legal/. To obtain a paper copy of this notice, please contact your campus or facility privacy officer.

You may complain to the Board if you believe your privacy rights, with respect to your PHI, have been violated by contacting the privacy officer on your campus or in your facility. Your must submit a written complaint. The Board will in no manner penalize you or retaliate against you for filing a complaint regarding the Board's privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You may contact the Secretary by calling 1-866-627-7748 (outside of metropolitan Atlanta) or (404) 562-7886 (in metropolitan Atlanta).

If you have any questions about this notice, please contact the Human Resources office on your campus or in your facility. For additional information, please contact the privacy officer on your campus or facility.

Effective Date: April 14, 2003

PLEASE NOTE:

On the following page you will find the ***CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION*** form. This form provides a spouse or another person/class of persons (organization) with the authority to act on behalf of another member. A signed authorization form provides access to PHI (protected health information) for an individual/organization other than the contract holder.

Should you need to access PHI for another individual, we ask that you photocopy this form and submit the completed form to your campus Human Resource/Personnel Office. Your institutional Human Resource/Personnel Office will forward a copy to the vendor (Business Associate/Agent) associated with your request.

Should you have any questions regarding the use of this form, please contact your campus Human Resource/Personnel Office for assistance.

**CONSENT FOR AUTHORIZATION FOR USE/RELEASE
OF HEALTH INFORMATION**

This authorization form applies only to the release and disclosure of protected health information (PHI). This authorization is not for treatment or intended for any other purpose.

By signing this form, I authorize my college, my university, my facility, or the University System office and Business Associates/Agents to use, release, or disclose the protected health information described below to:

Name and address of person/organization to whom information may be sent:

Transmit this information on or about (information will not be resent absent reauthorization):
___/___/___.

This authorization expires upon fulfillment of this request unless special circumstances apply.

Purpose for disclosure: _____

I authorize the following information to be sent to the address above:

___ Copies of all medical records for the period ___/___/___ to ___/___/___.

___ Copies of information described below for period ___/___/___ to ___/___/___.

___ History and Physical Examination ___ Lab Reports ___ Reports From Physicians

___ Other (specify) _____

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted diseases (STD); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

Please include on a separate piece of paper any other special instructions or limitations.

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of my college, university, facility, or University System policies and procedures for HIPAA Compliance and any changes thereto which may be associated with this authorization. I have been provided an opportunity to discuss any concerns I may have about the use or misuse of my health information with my institutional or facility privacy officer or other appropriate personnel.

I understand that my institution or facility, the University System of Georgia, or the Board of Regents of the University System of Georgia assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release the Board of

Regents of the University System of Georgia and its agents and employees from all legal liability that may arise from this authorization.

Name (please print): _____

Address: _____

Telephone: (____) _____

Fax: (____) _____

Group No.: _____

Group Name: _____

Member ID Number: _____

Social Security Number: _____

Signed: _____

Date of Birth: _____

Date this Authorization Executed: _____

If the signature above is not that of the person whose medical records are authorized to be released, I am acting for the person whose medical records are being authorized for release:

My relationship to such person is: _____

Signed: _____

The person whose medical records are hereby authorized for release or that person's representative may revoke this authorization by notifying in writing the privacy officer at the person's university, college or facility. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is otherwise prohibited by the Health Insurance Portability and Accountability Act of 1996. Federal law also requires a statement that there is a potential for the protected health information released under this authorization to be subject to redisclosure by the recipient.

FORM CREATED 29 JAN 03

FUTURE OF THE PLAN

The Board of Regents of the University System of Georgia is the plan sponsor for the self-insured PPO/PPO Consumer Choice healthcare plan. While the University System of Georgia expects the PPO/PPO Consumer Choice healthcare plan to remain in effect, the University System of Georgia reserves the right to change the plan, or any benefit under the plan, from time to time; or to discontinue the plan, or any benefit under the plan, at any time.

EMPLOYMENT RIGHTS NOT IMPLIED

Your participation in the PPO/PPO Consumer Choice healthcare plan is not a contract of employment - it does not guarantee you continued employment with the University System of Georgia. Nor does it limit the University System of Georgia's right to discharge you, without regard to the effect that your discharge would have on your rights under the PPO/PPO Consumer Choice healthcare plan. If you quit or if you are discharged, you have no right to future benefits from the plan except as specifically provided in this booklet and the benefit plan document.

GLOSSARY OF TERMS

This section of your health plan booklet provides terminology and phrases used throughout this document.

Acute Care

Care provided when such services are medically necessary and immediately required as a result of a sudden onset of illness or injury.

Balance Billing

The dollar amount charged by a provider that is in excess of the plan's allowed amount for medical care or treatment. Amounts that are balance billed by a provider are the member's responsibility. Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).

The University System of Georgia PPO/PPO Consumer Choice healthcare plan does not have the legal authority to intervene when a non-participating provider balance bills the member. Therefore, the healthcare plan cannot reduce or eliminate balance-billed amounts. The healthcare plan will not make additional payments above the plan allowed benefit limits.

Coinsurance

Coinsurance is the portion of the covered allowed charges that a member must pay, after he/she has met the appropriate deductible. If the healthcare plan covers 90% of the cost for a particular benefit, the member would be responsible for the remaining 10% of covered charges. The 10% of covered allowed charges, paid by the member, is deemed to be the *coinsurance* amount.

Contract Year

A period of one year commencing on the effective date (or renewal date) of a healthcare plan contract and ending at 12:00 midnight on the last day of the one year period. The *contract year* for the University System of Georgia begins on January 1 and concludes on December 31.

Co-payment

A *co-payment* is a fixed dollar amount that a member must pay for a particular service or item, such as a member *co-payment* for a prescription medication.

Covered Charges

The portion of a member's billed charges for medical treatment, services, or supplies that will be reimbursed by the healthcare plan.

Custodial Care

Custodial care is any type of care, including room and board, that: (a) does not require the skills of a professional or technical healthcare provider; (b) is not furnished by, nor is under the supervision of, such a professional or technical healthcare provider; (c) does not, otherwise, meet the requirements of a post-hospital skilled nursing facility care; or (d) is a level of care, such that a member has reached his/her maximum level of physical or mental function, and is not likely to make further significant improvements. Custodial care includes, but is not limited to, any type of care in which the primary purpose of care is to attend to the member's activities of daily living. Such care does not entail, nor require, the continuing attention or observation by trained medical or paramedical healthcare providers. Generally, care is considered *custodial*, if it can be provided by an untrained adult with little or no supervision.

Deductible

A *deductible* is a fixed dollar amount that a member must pay out-of-pocket, each plan year, before the healthcare plan will begin to pay for covered benefits.

Emergency Care

Emergency care is medical care that is provided for a sudden, severe, and/or unexpected illness/injury. If such care/treatment were not provided immediately, the results could be life threatening or could result in permanent impairment of bodily functions.

Explanation of Benefits (EOB)

An *Explanation of Benefits (EOB)* is an itemized statement of member-incurred medical charges. An EOB will identify paid or denied provider charges following the processing of a filed healthcare claim.

Hospice Care

Hospice care is a form of medical care that is provided for a patient who has been physician-certified as being terminally ill. *Hospice care* may be rendered in an inpatient or outpatient setting. The life expectancy of a hospice patient is generally deemed to be six months or less.

Hospital-based Physicians

Hospital-based physicians include, but are not limited to, anesthesiologists, emergency room physicians, pathologists, and radiologists.

Inpatient

A member, who is admitted to a hospital for medical treatment or services, and for whom, a room and board charge is paid. To be considered as *inpatient*, a hospital confinement must be for a period of at least 24 hours.

Lifetime Maximum Benefit

The *lifetime maximum benefit* is \$2,000,000. The *lifetime maximum benefit* reflects a cumulative total of all covered medical and pharmacy charges paid by the healthcare plan. ***Please be reminded that the lifetime maximum benefit for a USG covered member includes all covered charges paid by current and previous University System of Georgia Indemnity, PPO, HMO and HSA PPO (HDHP) healthcare plan contracts.***

Medical Utilization Management

Medical Utilization Management is a program that is administered by BCBSGa for all inpatient, and for specific outpatient, medical/surgical treatments and diagnostic tests. To access benefits coverage, BCBSGa must determine if: (1) a procedure is medically necessary; and/or (2) if an appropriate and alternative treatment is available. For additional information, please see page 38 of this booklet.

Medically Necessary

A service or treatment, which in the judgment of the healthcare plan, is both appropriate and consistent with a medical diagnosis. To meet the plan's criteria for medical necessity, any service or treatment must be widely accepted professionally within the United States as effective, appropriate, and essential. The treatment or service must be based on recognized standards of the healthcare specialty involved. The *medically necessary* treatment or service may not be experimental in nature; educational; or primarily for research or investigations.

Mental Health Disorders

Mental health disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and/or drug, alcohol or chemical dependency. *Mental health disorders* may be organic; non-organic; biological; non-biological; genetic; of chemical origin; of non-chemical origin; irrespective of cause, basis or inducement.

Non-Covered Charges

Services that are not covered by the healthcare benefit plan design.

Outpatient

A member who receives treatment from a hospital, urgent care facility or outpatient facility and is released to return home following treatment. To be considered as *outpatient*, treatment received in a facility must be for a period of less than 24 hours.

Out-of-Pocket Limit (Stop Loss)

An *out-of-pocket limit* is the maximum amount of healthcare plan expenses that a member will be required to pay during a plan year. Out-of-pocket expenses include member deductibles and member co-insurance payments required on an annual plan year basis. Once a member reaches his/her *out-of-pocket limit*, the healthcare plan will pay for 100% of covered expenses for the remainder of the plan year. ***Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).***

Partial/Day Hospitalization

This is a mental health/substance abuse benefit provided by BCBSGa. Under this benefit, a member may receive treatment sessions that are typically provided three to five times a week. Treatment sessions may be held during day or evening hours. Sessions generally last no longer than four (4) hours.

PHI (Personal Health Information)

Personal health information, which is protected from unauthorized disclosure by Board of Regents, by state statute, and by federal law, is referred to as “protected health information,” or “PHI.” PHI is defined as any individually identifiable health information regarding the medical/dental history, the mental or physical condition, or the medical treatment of an employee, a student, or a patient. Examples of PHI include patient name, address, telephone and/or fax number, electronic mail address, social security number or other patient identification number, date of birth, date of treatment, medical treatment records, medical enrollment records, or medical claims records.

Preferred Provider Organization (PPO)

A *Preferred Provider Organization (PPO)* is a comprehensive network of doctors, hospitals, and ancillary providers that have agreed to offer quality medical treatment, services and care at discounted rates. A member will receive the highest level of benefit coverage when using an in-network provider. A member may use an out-of-network provider, but he/she will receive a lower level of benefit coverage.

Provider

A *provider* is a licensed medical doctor, a plan-approved healthcare professional, and/or a hospital/medical facility.

Service Area

A *service area* consists of approved counties and geographic areas in which network services are available.

Disclaimer:

This booklet summarizes your PPO/PPO Consumer Choice healthcare plan. It is not intended to cover all the details of the PPO/PPO Consumer Choice healthcare plan. This booklet is not a contract and the benefits that are described can be terminated or amended by the University System of Georgia in its sole discretion. Should any questions arise, the master contract and the contract of the administration are the final authorities in determining benefits.

LEGISLATION PASSED BY THE 2008 GEORGIA GENERAL ASSEMBLY AND SIGNED BY THE GOVERNOR

There was no legislation passed by the 2008 session of the Georgia General Assembly that will impact the Board of Regents PPO/PPO Consumer Choice Health Benefits Plan Summary Document.

Disclaimer:

This information is provided for informational purposes only and no warranty is provided for accuracy. Members should consult legal counsel regarding legal rights and responsibilities.

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