BENEFIT BOOKLET
POS
Health Benefit Plan

COBB COUNTY GOVERNMENT
2010

Administered By

BlueCross BlueShield
Healthcare Plan of Georgia

NOTICE

This document, which is called the **Benefit Booklet,** describes the health plan (herein called the Plan) as established by **COBB COUNTY GOVERNMENT** (herein called the Employer or Plan Sponsor).

This Benefit Booklet is a part of the Employer's **Health Plan Document** which Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) (herein called the Claims Administrator), An Independent Licensee of the Blue Cross and Blue Shield Association, administers under the Employer's Self funded Plan.

Every effort has been made to accurately describe the Plan in this Benefit Booklet. However, if there should be a discrepancy between this Benefit Booklet and the Health Plan Document, or if the Plan is required to operate in a different manner to comply with federal laws and regulations, the Health Plan Document or the appropriate federal laws and regulations will govern.

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider attached hereto are self-insured by the Employer that is responsible for their payment. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. provides claim administration services for the Plan, but Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. does not insure the benefits described.

Table of Contents

Summary of Benefits ..... **ii**

Important Phone Numbers ..... **vii**

Eligibility **1**

How Benefits Work **7**

Pre-Admission Certification (PAC) **9**

Benefits **11**

Network Mental Health Care and Substance Abuse Treatment **24**

Limitations and Exclusions **25**

Coordination of Benefits (COB) **29**

Subrogation **31**

Claims and General Information **32**

When Coverage Terminates **36**

Definitions **40**

Mental Health Parity and Addiction Equity Act **51**

Statement of Rights Under the Women's Cancer Rights Act of 1998 ..... **52**

RESOLUTION **53**

Summary of Benefits	In-Network	Out-of-Network
All In-Network primary care must be received from your Primary Care Physician. A Participant may choose to receive treatment from any In-Network Specialist Physician without a Primary Care Physician Referral.		
Lifetime Maximum Benefits (All benefits combined)	**$1,000,000**	
Calendar Year Deductible (Maximum 3 per family) All Eligible Charges are subject to the Deductible, except those with Copayments, unless otherwise specified in this Benefit booklet. All surgical procedures are subject to Deductible and Coinsurance.	$300	$400
Percentage Payable (Unless Otherwise Specified) Plan Pays Participant Pays Percentage payable after the Out-of-Pocket Limit is met. All payments are based on Eligible Charges and negotiated arrangements.	 80% 20% 100%	 60% 40% 100%
Out-of-Pocket Limit Per Calendar Year (includes Deductible) Individual Family	 $1,500 $3,000	 $3,000 $9,000
Amounts satisfied toward the Out-of-Network Out-of-Pocket expense will be applied toward the In-Network Out-of-Pocket expense, and vice versa.		
Hospital Inpatient Services Room and Board (Semi-Private or ICU/CCU) Hospital Services and Supplies (x-ray, lab, anesthesia, etc.) Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	 80% 80% 80%	 60% 60% 60%
Outpatient Hospital Services Outpatient Surgery Facility Outpatient Lab, X-ray and Anesthesia Services Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	 80% 80% 80%	 60% 60% 60%
Chiropractic Care Spinal Manipulation, one treatment per day Visits Per Calendar Year	$20 20 Out-of-Network visits are combined with physical, occupational therapy, service of athletic trainers	80%
Emergency Room Copayment Life-threatening medical conditions or serious Accidental Injuries. Initial services rendered for the onset of symptoms for a life-threatening medical condition or serious Accidental Injury that requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. The emergency room Copayment is waived if admitted to the Hospital through the emergency room.	$100	$100

Summary of Benefits	In-Network	Out-of-Network
Non-Accidental Injury or Non-Medical Emergency Emergency Room Copayment Percentage payable after Copayment and calendar year Deductible	 $100 50%	 $100 50%
Inpatient Mental Health Care and Substance Abuse Treatment Hospital Inpatient Services Physician Hospital Services	 80% 80%	 60% 60%
Outpatient Mental Health Care and Substance Abuse Treatment Percentage payable per visit	 80%	 60%
Primary Care Physician/Specialist Physician Copayment/Coinsurance, per office visit Unless specifically stated, all services obtained as an outpatient at a Hospital (e.g., lab tests, x-rays, etc.) are covered subject to your Deductible and Coinsurance. Surgical procedures performed in an office are covered subject to your Deductible and Coinsurance. The following procedures may be performed by a Primary Care Physician or Specialist Physician. • Diagnostic X-ray and Lab • Injections for the Treatment of a Specific, Non-Chronic Medical Condition • Second Surgical Opinion Treatment of Accidental Injury	$20	60%
Preventive Health Care in the Physician's Office Copayments/Coinsurance, per office visit The following services may be performed by a Primary Care Physician or Specialist Physician. **Preventive Services for Children Age 5 and Under** • Periodic Health Assessments • Development assessment of the child • Age appropriate immunizations • Laboratory testing The Deductible does NOT apply to child wellness services for children through age 5.	$20	100% (Maximum $100 per Member, $300 per Family per Calendar Year) then 60%

Summary of Benefits	In-Network	Out-of-Network
Preventive Services (cont'd) **Preventive Services for Children Over Age 5 and Adults** Services include, but are not limited to: • Periodic Health Assessments • Immunizations • Flu Injections **Preventive Services for Women** • Annual Gynecological Exam • Mammography (the program pays 100% after the Copayment) • Pap Smear • Chlamydia Screening • Ovarian Surveillance • Colorectal Screening **Preventive Services for Men** • Prostate Screening • Colorectal Screening	$20	100% (Maximum $100 per Member, $300 per Family per Calendar Year) then 60% * See Note Below
***Note:** Copayments are not applicable to Out-of-Network services. Unless otherwise noted, these services are subject to the applicable Deductible and Coinsurance.		
Home Health Care Services	$20	60%
Visits Per Calendar Year	120	
Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Contract.		
Maternity Care Visits (*first visit only) (includes pre-and post-natal, delivery) (Physician charges only)	$100*	60%
Allergy Care (testing, serum and allergy shots)	80%	60%
Ambulance Service	80%	80%
Hospice Care Services	80%	60%
Lifetime Maximum	$25,000	
Physical Therapy	80%	60%
Visits Per Calendar Year	30	
Private Duty Nursing (RN or LPN)	80%	60%
Maximum Benefit Per Calendar Year	$2,500	
Respiratory Therapy	80%	60%
Visits Per Calendar Year	30	
Skilled Nursing Facility	80%	60%
Days Per Calendar Year	120	
Speech Therapy	80%	60%
Visits Per Calendar Year	30	
Temporomandibular Joint Syndrome (TMJ)	80%	60%
Lifetime Maximum Benefit	$2,500	

Types of Coverage

Your type of coverage is determined by your selection at the time of enrollment through the Employer.

Note: These benefits are valid for your Employer's current benefit period. You will receive a revised Summary of Benefits if there is a change in the benefits.

Summary Notice

This Benefit Booklet summarizes your Employer's health care benefit Plan. It is the benefit portion of the Health Plan Document, which governs the Plan's coverage. The Health Plan Document, and any riders and/or amendments comprise the entire Plan between the Employer and the Claims Administrator.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Benefit Booklet carefully. If you have any questions about your benefits as presented in this Benefit Booklet, please contact your Employer's Plan Administrator or call the Claims Administrator's Customer Service Department.

This Benefit Booklet makes up the Covered Services provisions of the Health Plan Document. Its purpose is to help you understand your coverage and to provide an explanation of the benefits that the Employer offers. Further terms and conditions of the health care coverage and other benefits are contained in the Health Plan Document. A copy of the Health Plan Document is held by your Employer; however, this Benefit Booklet provides the health benefits for easy reference.

Important Phone Numbers

Pre-Admission Certification (PAC)
For In-Network benefits, you should call your Primary Care Physician.

For Out-of-Network benefits, you are responsible for obtaining pre-certification.

You, your Physician or the Hospital should call the following number for Pre-Admission Certification:
1-800-722-6614

Customer Service
If you have a customer service question, please call:
1-800-441-CARE (2273)

Special Phone Numbers
Please check your ID card for telephone numbers unique to your Group.

Hospital Audit Program
(Effective Date: Adopted 8/92**)**

Purpose
To encourage and solicit the self-audit of medical benefit participant hospital bills and to reimburse participants for 50% of all eligible cost savings up to a maximum reimbursement of $750 that are properly submitted and accepted.

Scope
- All employees, retirees and COBRA participants who are eligible for the medical benefit are eligible to participate and receive reimbursement.
- All charges in respect to the inpatient hospital confinement for medical plan participants and dependents are eligible for the self-audit process.

Procedures

Audit Suggestion
Medical plan participants should look for billing errors that include but are not limited to:

1. Subtract room and board from total amount of bill. If any one item is greater than 20%, it should be investigated
2. Lab tests never received
3. Medications not taken
4. Medications over $50
5. Procedures not performed
6. Rental charges for extra days
7. Charges for more than 8 diapers a day unless the baby has diarrhea
8. Charges for more than one pillow
9. Medical plan participants should take own personal items and slippers
10. Charges for the day of admission and the day of discharge
11. Transposed numbers

Evaluation Process

1. The medical benefit participant should request a copy of the hospital bill from the provider hospital or the Claims Service Administrator.
2. If any errors are found, the medical benefit participant should notify the provider hospital and furnish Personnel Department a copy of the inaccurate bill and define, in writing, the potential error.
3. The provider hospital should give the medical plan participant a corrected bill which should be given to the Personnel Department.
4. The corrected bill and accompanying documentation should be forwarded to the Claims Service Administrator to determine the eligible amount of savings.

Reimbursement Process

1. The Claims Service Administrator should recover 100% of cost savings from the provider hospital and credit the medical benefit fund.
2. The Claims Service Administrator representative will communicate the eligible reimbursement (50%) due to the medical benefit participant.
3. The Personnel Department will coordinate the authorized medical benefit participant reimbursement with the Finance Department.
4. Medical benefit participant reimbursements will be funded from the medical benefit fund.

Program Conditions

1. No oral or anonymous reimbursement requests will be considered or accepted.
2. All reimbursements are considered taxable income to the medical plan participant. The appropriate amounts will be included on year-end tax statements.
3. The decision of the Claims Administrator concerning eligible reimbursement is final.
4. No interest will be paid on reimbursement awards.

Eligibility

This health Plan contains a 6-month Employee and 12-month Dependent pre-existing conditions waiting period, except for maternity benefits. Participants who do not enroll within 30 days of being eligible are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Coverage for the Employee

This Benefit Booklet describes the benefits an Employee may receive under this health care Plan. The Employee is also called a Participant.

Eligibility for Benefits:

Upon enrollment in the Plan, the Employee, his Spouse and eligible dependents shall become Participants for the benefits provided by this Plan, subject to the limitations contained in the applicable Plan provisions. Eligibility changes will only be considered during the annual open enrollment period unless the change is requested as a result of an Authorized Family Status Change or accompanied by a Qualified Medical Child Support Order. In each of these incidents, eligibility could be subject to Late Enrollment procedures if received by the Employer after 30 days from initially being eligible.

Individuals Eligible for Benefits:

- All full-time Employees of Cobb County who work at least thirty (30) hours per week;
- Retired Employees from the Cobb County Government Employees' Pension Plan, the Library System Retirement Plan, or State Retirement System, or any municipality that is participating in the Cobb County Health Benefit Plan are subject to the following:

Effective January 1, 2006:

- All full-time new hires or rehires will be eligible to continue medical coverage with twenty (20) years of service at termination of employment to immediately commence retirement.

Effective January 1, 2007:

- All full-time employees with seven (7) or more years of service as of the effective date will be eligible to continue medical coverage with ten (10) years of service at termination of employment immediately before commencement of retirement benefits.
- All full-time employees with less than seven (7) years of service as of the effective date will be eligible to continue medical coverage with fifteen (15) years of service at termination of employment immediately before commencement of retirement benefits.
    - Effective January 1, 2010 – Employees within this definition of eligibility who elect to retire prior to age 65 and prior to 15 years of service may participate in the health benefit until the end of the month of their 65th birthday. Cobb County will contribute 2.5 percent of health premium cost for each full year of service up to a maximum of 30 years of service (75%).

Effective January 1, 2009

- All full-time new hires or rehires will be eligible to continue medical coverage with thirty (30) years of service at termination of employment to immediately commence retirement.

Effective January 1, 2010

- Cobb County will continue 2.5 percent of health premium cost for each year of service up to a maximum of 30 years of service (75%). Those employees meeting eligibility requirements for retiree health coverage prior to January 1, 2010 will not be subject to this provision.
- All disabled Employees of Cobb County Government if:
    - They were disabled on or after November 1, 1998;
    - They are eligible and receive monthly compensation benefits from the Cobb County Government Board of Commissioners group Long Term Disability Plan; and
    - They have been continuously covered for medical care benefits for at least ten years as an Employee (or as his Spouse's dependent) under the Health Benefit Plan or under any other policy or plan sponsored or arranged by the sponsor, just before the date of his disability.

Coverage for the Employee's Dependents

If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. The Employee's Covered Dependents are also called Participants.

If the wrong birth date of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Any overpayment made under these conditions will be refunded by the Employee or Employer.

Eligible Dependents Include:

- The Employee's Spouse (For the purpose of this Plan, a Spouse is defined as a person of the opposite sex who is married to the enrolling Employee);
- The Employee's unmarried dependent children. Also included are the legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren, the Employee's children (or children of the Employee's Spouse) for whom the Employee has legal responsibility resulting from a valid court decree until attaining age 19. Children may be covered until attaining age 26 provided they remain the Employee's Dependents and, in each calendar year since reaching age 19, are enrolled as full-time students in a post-secondary institution of higher learning for five calendar months or more. Children up to and including age 25 that were required to withdraw enrollment from a post-secondary institution, prevented from enrollment, or required to reduce enrollment below the level required for full-time status as a result of an injury or illness shall be entitled to the same benefits as if the Dependent continued to be enrolled as a full-time student. The student will be covered until December 31 of that year, provided they are enrolled 5 months of a calendar year. If the student is enrolled during the fifth month, they are considered enrolled for the entire month. Employees are required to submit notification for full-time student status with a copy of a school transcript showing enrollment and credit hours each year. Once the dependent no longer meets the eligibility requirements for student status, employees are required to submit to Human Resources a Benefit Change Form to cancel coverage.
- Unmarried children who are mentally or physically handicapped and totally dependent on the Employee for support, regardless of age with the exception of incapacitated children age 19 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan prior to reaching age 19. Certification of the handicap is required within 30 days of attainment of age 19. A certification form is available from the Employer or from the Claims Administrator and may be required periodically.
- If both the Employee and his Spouse are employees of two different employers under the Cobb County Plan, each employee must be covered by his employed jurisdiction. In no event may either employee be covered both as an Employee and as a dependent under the Plan. If either employee should leave their jurisdiction, the other employee may pick up that Spouse and/or dependent children under his plan within 30 days of the break in service, with no waiting periods or special requirements.

Initial Enrollees

Initial Enrollees and eligible Dependents, who were previously enrolled under group coverage that this Plan replaces, are eligible for coverage on the Effective Date of this coverage.

New Hires

Applications for enrollment must be submitted within 30 days from the date the Employee is eligible, as set by the Employer. Applications for membership may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Employer. If the Employee or the Employee's Dependents do not enroll when first eligible, the Employee and the Employee's Dependents will be treated as Late Enrollees. Please refer to the "**Late Enrollees"** provision listed below.

Late Enrollees

If the Employee or the Employee's Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Employee or the Employee's Dependents may be eligible for special enrollment as set out below.

Special Enrollment Periods

There are special enrollment periods for Employees or Dependents who:

- Originally declined coverage because of other coverage, and
- Who exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated.
- An individual who declined coverage must have certified in writing that they are covered by another health plan when they initially declined coverage under this Plan in order to later qualify under this special enrollment. Persons declining coverage will be given notice of the consequences when they originally decline coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births, or adoptions. If a birth or adoption occurs and the new Dependent is enrolled within 30 days of the birth or adoption, then no twelve (12) month pre-existing condition waiting period will apply. The un-enrolled Participant may enroll within 30 days of such a special qualifying event.

Important Notes:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees and are subject to the normal pre-existing condition requirements (excluding newborns, adoptions and pregnancies).
- Individuals or Dependents must request coverage within 30 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Coverage Begins

If the Employee applies when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires; however, the Employee will receive credit toward the pre-existing conditions waiting period for any employee length-of-service requirements that the Employee must serve.

Changing Coverage

There may be an annual re-enrollment period during which time Participants may elect to change their options.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)

As the Employee's family increases, the Employee may add new Dependents by contacting the Plan Administrator. The Employee or the Plan Administrator must notify the Claims Administrator in writing. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Employee has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete within 30 days of the event:

- Change in legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent;
- Change in employment status, including termination or commencement of employment of the employee, Spouse or dependent
- Changes in work schedule, including an increase or decrease in the number of hours of employment by the employee, Spouse or dependent, including a switch between full time and part time status, a strike or lockout or commencement or return from unpaid leave of absence.

- Enrolled Dependent child satisfies or ceases to satisfy the requirements for unmarried dependents (reaches age 19) or the Dependent marries (see "When Coverage Terminates") or no longer meets the requirements of full time student status;
- Enrolled Dependent child becomes totally or permanently disabled.
- A change in the place of residence or worksite of the employee, Spouse or dependent that affects eligibility under the plan.

Marriage and Stepchildren

An Employee may add a Spouse and eligible stepchildren within 31-days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage. Remember, there will be an additional charge.

If an Employee does not apply for coverage to add a Spouse and stepchildren within 31-days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the **"Late Enrollees"** provision in this section.

Newborn and Adopted Children

A newborn or an adopted child is covered automatically for 30 days from the moment of birth or date of assumption of legal responsibility up to age 19. If additional Premium is required to continue coverage beyond the 30-day period, the Employee must notify the Plan Administrator of the birth or adoption and pay the required Premium within the 30-day period or coverage will terminate. Types of coverage requiring additional Premium include One-Person Coverage and Two-Person Coverage.

If an Employee has Family Coverage or Multi-Person Coverage, no additional Premium is required and coverage automatically continues. However, the Employee should notify the Plan Administrator of the birth or adoption within 30-days to ensure accurate records and timely payment of claims.

Extending coverage for a newborn child or an adopted child being added to One-Person or Two-Person Coverage beyond the 30-day period requires Late Enrollment. Please refer to the **"Late Enrollees"** provision in this section.

Foster Children

Foster children are children of those whose parental rights have been terminated by the state and who have been placed in an alternative living situation by the state. A child does not become a foster child when the parents voluntarily relinquish parental power to a third party.

Foster children for whom an Employee assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, an Employee must provide confirmation of a valid foster parent relationship to the Claims Administrator. Such confirmation must be furnished at the Employee's expense. When the application is processed, the Effective Date will be the first of the month following your Employer's Employee waiting period.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).
An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final. Pre-existing condition limitations will not apply to the child as long as the adoption (or placement for adoption) occurs while the Employee is eligible for coverage.
  - An "adopted child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received an MCSO (a "Medical Child Support Order") that has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO").
  - Upon receipt of an MCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

If the Employee Has To Be Away From Work

The Employer may (but is not required to) consider the Employee as an active Employee (and continue the Employee's coverage) even though the Employee is:

- Put on approval leave of absence; or
- Unable to work because of Injury or sickness;
- On approved FMLA leave of absence. In all events, the Plan will be administered in accordance with the requirement of the FMLA.

The employer must treat all Employees the same for purposes of continuing coverage under the Health Benefit Plan. If the Employee's coverage is so continued, it will be on the earliest of the following date:

- The date the Employer no longer considers the Employee as an active Employee;
- The date which ends the period for which the contribution for the Employee's coverage was last paid; or
- The date that ends the Maximum Continuation Period for which the coverage can be continued. The Maximum Continuation Period is shown below:

For Absence Due To

Approved leave of absence (Other than Injury or Sickness)

Maximum Continuation Period

90 days

The Employee must pay any applicable contribution during his absence.

For Absence Due To

Injury or Sickness

Maximum Continuation Period

90-day periods, each of which begins as follows, but no more than one year from the date the Employee was last at Active Work;

The first 90-day period begins on the date the Employee stops Active Work due to Injury or Sickness;

The Employee must pay any applicable contribution during his absence.

For each 90-day period after that, the Employee must furnish proof from his doctor of his continued inability to work due to Injury or Sickness.

The Employee must pay any applicable contribution during his absence.

For Absence Due To
Approved Family Medical Leave Act of Absence

Maximum Continuation Period
12 weeks

The Employee must pay any applicable contribution during his absence.

If an Employee is receiving long-term disability benefits from the Employer's group plan and has a minimum of ten (10) years of service, health benefits may be continued indefinitely.

If an employee must be away from active work for any reason, the Employee will need to contact the Employer.

Family and Medical Leave
If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions that would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Employee Not Actively at Work

New Hires
Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.

Portability Provision
The Effective Date of coverage is subject to any length-of-service provision the Employer requires. A newly eligible person is an individual who was not previously eligible for coverage under this Plan. There is a pre-existing waiting period imposed following the Effective Date of coverage.

How Benefits Work

Note: Capitalized terms such as Covered Services, Medical Necessity, Network Hospitals and Out-of-Pocket Limit are defined in the "Definitions" section.

Introduction

BlueChoice Option is a comprehensive plan that provides Primary and other health care services. **All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.** All In-Network primary care must be received from your Primary Care Physician. A Participant may access specialty care directly from an In-Network Specialist Physician; no PCP Referral is needed.

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

BlueChoice Option provides Point-of-Service Benefits

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

Copayment or Out-of-Network Out-of-Pocket

Whether you choose In-Network or Out-of-Network benefits, you will be charged a Copayment or an Out-of-Pocket amount for certain services, that may be a flat-dollar amount or a percentage of the total charge. Any Copayment amounts required are shown in the **Summary of Benefits**. The emergency room Copayment is waived if a Member is admitted to the Hospital through the emergency room.

What Your Program Pays

The Calendar Year Deductible

Before your program begins to pay benefits, you must meet any **Deductible** required. Deductible requirements are stated in the **Summary of Benefits**.

Carry Over Deductible

Eligible Charges during the last three months of a calendar year applied to that year's Deductible can carry over and also apply toward the next year's Deductible.

Coinsurance and Out-of-Pocket Limit

The **percentage payable** by the Plan is stated in the **Summary of Benefits**. The portion that you must pay (the Coinsurance) is stated in the **Summary of Benefits**. After you reach your Out-of-Pocket Limit (plus any required Deductible), the Plan pays 100% of Eligible Charges for the remainder of the calendar year. The Out-of-Pocket Limit benefit does not apply to:

- Any Copayment; or
- Any mental health care and Substance Abuse treatment.

These services are never paid at 100%.

See the Summary of Benefits to determine if you have an In-Network Coinsurance Amount and an In-Network Out-of-Pocket Limit.

Eligible Charges

For In-Network services, Eligible Charges are determined by: (a) BCBSHP's negotiated arrangements; (b) pre-determined fee schedules; and (c) the applicable Reimbursement Rate. For Out-of-Network services, Eligible Charges are determined by: (a) BCBSHP's Usual, Customary and Reasonable (UCR) Fees; (b) a Provider's contracted fee schedule; (c) the applicable Reimbursement Rate; or (d) negotiated fees. Reimbursement for Out-of-Network and Participating Providers is based on Eligible Charges for the type of service a Member receives, for example, Hospital or Physician services. Reimbursement for Non-Contracted Providers is determined by our Default Reimbursement Rate.

Lifetime Maximum Benefit

The Lifetime Maximum Benefit outlined in the **Summary of Benefits** includes all payments made under this Plan with BCBSHP or its affiliates.

All services and all calendar year maximums—whether for a number of days or visits, treatments or yearly dollar limit—are subject to the Lifetime Maximum Benefit.

Pre-Admission Certification (PAC)

Hospital Pre-certification

The Pre-Admission Certification Process

- Length-of-Stay Assignment indicates the number of Inpatient days usually Medically Necessary to treat a condition;
- Continued Stay Review/Concurrent Review determines whether a continued Inpatient stay is Medically Necessary. If your stay exceeds the number of days assigned under this program, the Hospital's charge for additional days beyond the assigned length of stay will not be paid. If all Primary Care Physician or specialist guidelines are followed, you will not be responsible for any Eligible Hospital charge in excess of any applicable Copayment or Coinsurance amounts. If you receive Out-of-Network Care, you will be responsible for the Hospital's charges;
- Admission Review determines whether an unscheduled Inpatient admission or an admission not subject to pre-certification was Medically Necessary;
- Discharge Planning assesses the Participant's need for additional treatment after Hospital discharge.

In-Network Care

- If you are hospitalized other than in an emergency or for 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. This means you will not be responsible for any bill in excess of the Copayments or Coinsurance that apply.
- Ineligible Charges and Non-Covered Services are always the Participant's responsibility.
- PAC is the responsibility of the admitting Physician.

Out-of-Network Care

- You, the Physician or the Hospital **must** obtain approval for all Hospital admissions.
- If you are hospitalized other than in an emergency or for a maternity delivery admission and Pre-Admission Certification was not obtained, all charges will be denied. You—the Participant—will be responsible for the Hospital's charges in addition to any Deductible, Copayment, Coinsurance and Ineligible Charges.
- If you obtained PAC but exceed the number of days allowed through the PAC process, you will be responsible for the charges for those days.
- If you are admitted to a 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.
- Ineligible Charges are always the Participant's responsibility.

Pre-Admission Certification is not a guarantee of payment

Admissions are approved only when the appropriateness of the Inpatient setting can be substantiated. Actual payment is based upon eligibility for coverage and the Effective Date for any Participant and also will be dependent on, but not limited to, specific Plan coverage and the status of the coverage on the date services are rendered. The Plan will not cover services related to specific Contract exclusions and limitations, including but not limited to, Custodial Care, Experimental or Investigational procedures, pre-existing conditions during the waiting period and services determined not Medically Necessary.

Outpatient Pre-certification Requirements

Outpatient pre-certification is a requirement for both In-Network and Out-of Network benefits. Your Contract provides Covered Services when outpatient services are Medically Necessary. Certain outpatient procedures require pre-certification from BCBSHP. Such services include, but are not limited to, outpatient surgical procedures, diagnostic imaging procedures, laboratory services, and Durable Medical Equipment.

Pre-certification is required for the following outpatient procedures:

- Arthroscopy – shoulder & knee
- Biofeedback
- CT Scan (Computed Tomography Scan)
- CTA
- Echocardiography (if not ordered by a Cardiologist)
- Home Health Care
- Hysterectomy (under age 35)
- MRA
- MRI
- Nuclear Cardiology
- Orthognathic/TMJ
- PET
- Reconstructive Surgery
- Sleep Studies
- Transplant Evaluations – Call (866) 694-0724 or fax (888) 896-8679
- UPPP

(This list is subject to change.)

If you have any questions regarding these pre-certification requirements, please contact Customer Service at the number listed on your ID card.

Benefits

All Covered Services must be Medically Necessary.

Ambulance Service
Local service to a Hospital in connection with care for a Medical Emergency or, if otherwise Medically Necessary. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

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

Pre-certification is required.

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

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

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

Cardiac Rehabilitation
Programs require pre-certification and Individual Case Management.

Chiropractic Care
Covered Services for In-Network Spinal Manipulation are available **only** if stated in the **Summary of Benefits**.

Clinical Trial Programs for Treatment of Children's Cancer
Covered Services include routine patient care costs incurred in connection with the provision of goods, services, and benefits to Participants who are dependent children in connection with approved clinical trial programs for the treatment of children's cancer. Routine patient care costs means those Medically Necessary costs as provided in Georgia law (OCGA 33-24-59.1).

Complications of Pregnancy
Benefits are provided for Complications of Pregnancy (see "Definitions"), resulting from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but are adversely affected or caused by pregnancy. Benefits for a normal or difficult delivery are not covered under this provision. Benefits are determined solely by the maternity section of this Benefit Booklet.

Consultation Services
Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered and payable at regular Plan benefits.

Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Plan.

Diabetes
Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

Dialysis Treatment
Dialysis treatment is covered for care when approval has been obtained by the Participant. The Plan will pay secondary to Medicare Part B, even if a Participant has not applied for eligible coverage available through Medicare.

Durable Medical Equipment
This Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity and applicable pre-certification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Participant's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:
- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the patient's physical disorder.

Emergency Care
Life-threatening Medical Emergency or Serious Accidental Injury.

Coverage is provided for hospital emergency room care for initial services rendered for the onset of symptoms for a life-threatening condition or serious Accidental Injury that requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is such a nature that failure to obtain immediate medical care could place his or her life in danger or cause serious harm.

A Copayment is required for In-Network and Out-of-Network care. The Copayment is waived if a Participant is admitted to the Hospital through the emergency room. The Copayment and percentage payable are shown in the **Summary of Benefits** and are the same for both In-Network and Out-of-Network care.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Services of a Certified Registered Nurse Anesthetist (CRNA) will be covered only when billed for by the supervising anesthesiologist.

Home Health Care Services

Home Health Care provides a program for the Participant's care and treatment in the home. Your coverage is outlined in the **Summary of Benefits**. A visit consists of up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Participant's attending Physician.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis.
- A Participant must be essentially confined at home.

Covered Services Include:

- Visits by an RN or LPN - Benefits cannot be provided for services if the nurse is related to the Participant.
- Visits by a qualified physiotherapist, speech therapist or by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Participant to understand the emotional, social, and environmental factors resulting from or affecting the Participant's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who ordinarily resides in the patient's home or is a member of the family of either the patient or patient's Spouse.
- Any services for any period during which the Participant is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Participant has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietitian services.
- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.
- Private duty nursing care.

Hospice Care Services

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

Your Plan provides Covered Services for Inpatient and outpatient Hospice care as stated in the **Summary of Benefits**. The Hospice treatment program must:

- Be recognized as an approved Hospice program by the Claims Administration;
- Include support services to help covered family members deal with the patient's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
  - provides an organized system of home care;
  - uses a Hospice team; and
  - has around-the-clock care available.

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

Hospital Services (Network)

For In-Network care, your Physician must arrange your admission. Your Plan provides Covered Services when the following services are Medically Necessary.

In-Patient

In-Patient Hospital Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, Eligible Charges are based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that has only private rooms, Eligible Charges are based on the Hospital's prevalent room rate.

Service and Supplies

- Your benefits cover services and supplies provided and billed by the Hospital while you're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation therapy and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Outpatient

Outpatient Services

Your Plan provides Covered Services when the following outpatient services are Medically Necessary: Pre-admission tests, surgery, diagnostic x-rays and laboratory services. Certain procedures require pre-certification.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each Physician during the covered period of confinement.

Individual Case Management

The individual case management program is designed to ensure and provide payment of benefits to eligible Participants who, with their attending Physician, agree to treatment under an Alternative Benefit Plan intended to provide quality health care under lower cost alternatives. Such benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each Plan Participant.

The program includes:

- the identification of potential program participants through active case finding and referral mechanisms;
- eligibility screening;
- preparation of alternative benefit plans;
- subsequent to the approval of the parties, transfer to alternative treatment settings in which quality care will be provided.

Eligibility

A Participant receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Plan benefits.

The Plan is responsible for determining eligibility for cases to be included in the program.

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

Benefits

Benefits will be determined on a case-specific basis, depending on the plan of treatment, and may include Covered Services under the applicable Plan.

Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is less expensive than the original treatment plan which otherwise would have been followed. The Plan will determine the maximum approved payments allowable under the program.

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

- Services, equipment and supplies that are approved as Medically Necessary for the treatment and care of the Participant.
- Non-structural modifications to the home that are required to meet minimum standards for safe operation of equipment.
- When necessary for the long term care of the Participant in the home-setting, Respite Care to relieve family members or other persons caring for the Participant at home. (The Respite Care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. The Claims Administrator may approve on an exception basis up to 5 days per month of Respite Care when medical review of the case indicates that such action is appropriate. Payments for Respite Care will be deducted from the Participant's remaining available benefits under the Plan.)

The Participant must obtain pre-certification regarding the treatment plan and proposed setting to be utilized during the Respite Care period.

Potential cases include but are not limited to:

- spinal cord Injury;
- severe head trauma/coma;
- respiratory dependence;
- degenerative muscular/neurological disorders;
- long term IV antibiotics;

- premature birth;
- burns;
- cardiovascular accident;
- cancer;
- accidents;
- terminal illnesses;
- other cases at the Plan's discretion.

Covered Services

- Services covered under individual case management will be determined by the Plan on a case-by-case basis. Benefits may be provided for the rehabilitation of a Participant on an Inpatient, outpatient, or out-of-Hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.
- The program may provide or coordinate any of the types of Covered Services provided pursuant to this Benefit Booklet.
- At its sole discretion, in the context of an individual case management program, the Plan may also provide or arrange for alternative services or extra-contractual benefits which are either (i) excluded by this Benefit Booklet; (ii) neither excluded nor defined as Covered Services under this Benefit Booklet, or (iii) exceeding the maximum for any Covered Service under this Benefit Booklet.

Utilization

- Benefits will be provided only when and for as long as the Plan deems Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long, and shall be subject to pre-certification and continuing review for Medical Necessity as set forth in such plan for treatment.
- The total benefits paid under this program will not exceed those that the Participant would have otherwise received in the absence of individual case management benefits.

Exclusions

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

Individual Case Management Definitions

Case Manager
The person designated by the Claims Administrator to manage and coordinate the Participant's medical benefits under the individual case management program.

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

Termination of Individual Case Management
Services in the alternative benefit plan approved by the Claims Administrator under individual case management will cease to be Covered Services under this Plan when:

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

Licensed Speech Therapist Services

The Participant must obtain pre-certification. Developmental Delay will be covered when it is more than two standard deviations from the norm as defined by standardized, validated developmental screening tests such as the Denver Developmental Screening Test. Services will be covered only to treat or promote recovery of the specific functional deficits identified.

Maternity Care

Covered Services are provided for In-Network Maternity Care subject to the Copayment stated in the **Summary of Benefits**. If you choose an Out-of-Network provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Summary of Benefits**.

Maternity benefits are provided for a female Employee and the Spouse of a male employee. Maternity benefits for a dependent child are not covered.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name (see "Changing Coverage" (Adding a Dependent) to add a newborn to your coverage).

Under federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require prior certification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the mother's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the mother will have access to two post-discharge follow-up visits within the 48- or 96-hour period. These visits may be provided either in the Physician's office or in the mother's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the mother's attending Physician.

For In-Network Physician's care for prenatal care visits, delivery and postpartum visit(s), only one (1) Copayment will be charged.

Medical and Surgical Care

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

Non-Contracted Freestanding Ambulatory Facility

Any services rendered or supplies provided while you are a patient or receives services at or from a Non-Contracted Freestanding Ambulatory Facilities will be payable at 50% of the Default Reimbursement Rate.

Nutritional Counseling

Nutritional counseling related to the medical management of a disease states (subject to pre-certification).

Obesity

Covered Services for obesity include up to two nutritional counseling visits when referred by your Physician. Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan. Pre-certification is required, and coverage is only provided for gastric bypass or vertically banded gastroplasty.

Optometrist's Services

Services within the lawful scope of practice of and rendered personally by a licensed optometrist (O.D.) for which payment would be made under this Plan to a Physician providing the same services.

Oral Surgery

Pre-certification is required and must be obtained by the Participant. Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Removal of impacted teeth and associated hospitalization, but only if pre-certified. Pre-certification must be obtained by the Participant;
- Treatment of Temporomandibular Joint Syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures). TMJ is subject to a Lifetime Maximum Benefit per Participant as stated in the **Summary of Benefits**.
- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that will lead to functional impairments; and
- 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 Participant is covered by this Plan and performed within 180 days after the accident.

Organ/Tissue/Bone Marrow Transplant

Covered Services include certain services and supplies not otherwise excluded in this Benefit Booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (donor costs), post-operative care (including antirejection drug treatment, if Prescription Drugs are covered under the Plan) and transplant related chemotherapy for cancer limited as follows.

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

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

A covered transplant means a medically appropriate transplant of one of the following organs or tissues only and no others.

- Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.
- Autologous (self-donor) bone marrow transplants with high-dose chemotherapy are considered eligible for coverage on a prior approval basis, but **only** if required in the treatment of:
  - Non-Hodgkin’s lymphoma, intermediate or high grade Stage III or IVB;
  - Hodgkin’s disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
  - Neuroblastoma, Stage III or Stage IV;
  - Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have an HLA-compatible donor available for allogenic bone marrow support;
  - Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds;
  - Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
  - Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse.
- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:
  - aplastic anemia;
  - acute leukemia;
  - severe combined immunodeficiency **exclusive** of acquired immune deficiency syndrome (AIDS);
  - infantile malignant osteoporosis;

- chronic myelogenous leukemia;
- lymphoma (Wiscott-Aldrich syndrome);
- lysosomal storage disorder;
- myelodysplastic syndrome.

"Donor Costs" means all costs, direct and indirect (including administration costs), incurred in connection with:
- medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- preserving it; and
- transporting it to the site where the transplant is performed.

In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports.

For purposes of this benefit, the term "transplant" does not include transplant of blood or blood derivatives (except hematopoietic stem cells) that will be considered as nontransplant related under the terms of the Plan.

"Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and antirejection drugs.

"Medically Appropriate" means the recipient or self-donor meets the criteria for a transplant established by the Plan.

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

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

Pre-certification Requirement
All transplant procedures must be pre-certified for type of transplant and be Medically Appropriate according to criteria established by the Plan. To pre-certify, call the Claims Administrator's office using the telephone number on your Identification Card.

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

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

If the transplant involves a living donor, benefits are as follows:
- If a Participant receives a transplant and the donor is also covered under this Plan, payment for the Participant and the donor will be made under each individual's coverage.
- If the donor is not covered under this Plan, payment for the Participant and the donor will be made under this Plan but will be limited by any payment which might be made under any other hospitalization coverage plan.
- If the Participant is the donor and the recipient is not covered under this Plan, payment for the Participant will be made under this Plan limited by any payment that might be made by the recipient's hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

Please see the Exclusions section for Non-Covered Services.

Osteoporosis
Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Participants meeting Plan's criteria.

Other Covered Services
Your Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and Radioisotope, Radiation and Nuclear Medicine Therapy
- Diagnostic X-ray and Laboratory Procedures
- Dressings, Splints, Casts when provided by a covered Physician
- Oxygen, Blood and Components, and Administration
- Pacemakers and Electrodes
- Use of Operating and Treatment Rooms and Equipment

Outpatient CT scans and MRIs
These services will be subject to the Participant's Deductible and Coinsurance regardless of the provider setting-Physician's office or Hospital setting.

Outpatient Surgery
Outpatient surgery charges are covered at regular Plan benefits. These benefits are subject to both Deductible and percentage payable requirements.

Ovarian Cancer Surveillance Tests
Covered Services are provided for at risk women 35 years of age and older. At risk women are defined as: (a) having a family history (i) with one or more first or second-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, (iii) of nonpolysis colorectal cancer; or (b) testing positive for BRCA1 or BRCA2 mutations.

Surveillance tests means annual screening using: (a) CA-125 serum tumor marker testing, (b) transvaginal ultrasound, and (c) pelvic examinations.

Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers
Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), limited to a combined total maximum visits per calendar year as outlined in the **Summary of Benefits**. Out-of-Network care includes services for a licensed chiropractor (D.C.) or qualified athletic trainers. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when service is necessitated by Developmental Delay.

Physician Services
In-Network visits to a Physician's office are subject to the per visit Copayment indicated in the **Summary of Benefits**.

Preventive Care (In-Network)
The following services are Covered Services only if performed In-Network by your Primary Care Physician or by an obstetrician or gynecologist who is a Network Physician:

In-Network
The following services are Covered Services only if performed In-Network by your Primary Care Physician or by an obstetrician or gynecologist who is a Network Physician.

Visits to a Physician's office are subject to the per visit Copayment indicated in the **Summary of Benefits**.

Covered Services in the Physician's office include, but are not limited to:

- Treatment or preventive services including periodic health examinations for adults and Dependent children under the age of 19. Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs or insurance-related physicals are not covered;
- Treatment of Accidental Injury;
- Well child care for the following:
  - Birth to 1 year: six office visits a year and immunizations for hepatitis b, diphtheria, polio, measles, mumps, red measles, and influenza;
  - One year to age three: two office visits a year and necessary immunizations as stated above;
  - Three years through age 5: one visit a year and necessary immunizations as stated above; and
  - Two blood and urine tests and 3 TB tests are covered during the birth to 5 year period.
- Immunizations for dependent children under the age of 19;
- Flu injections;
- Gynecological tissue examinations and prostate screenings are covered at the same frequency guidelines listed below for Out-of-Network;
- One Chlamydia screening test for female Participants who are not more than 29 years old; or covered females who are more than 29 years of age, if ordered by a Physician.
- Mammograms are covered as stated in the Summary of Benefits at the same frequency guidelines listed below for Out-of-Network.

Out-of-Network
The following services are covered Out-of-Network, subject to your Deductible and Out-of-Pocket requirements.

Mammogram
Mammograms (x-ray procedure only) with the following frequency:
Once as a base-line mammogram for any female between 35 and 40 years of age;
Once every two years for any female between 40 and 50 years of age;
Once every year for any female age 50 or above; and

When recommended by a Physician for a female considered at risk. Female at risk means a female:
Who has a personal history of breast cancer;
Who has a personal history of biopsy proven benign breast disease;
Whose grandmother, mother, sister, or daughter has had breast cancer; or
Who has not given birth prior to age 30.

Pap Smear
One pap smear tissue examination per year, or more often when ordered by a Physician.

Prostate Antigen Test
Annual prostate specific antigen tests for covered males who are 45 years of age or older; or covered males who are 40 years of age or older, if ordered by a Physician.

Annual Chlamydia Screening Test
One annual Chlamydia screening test for female Participants who are not more than 29 years old; or covered females who are more than 29 years of age, if ordered by a Physician.

Primary Care Physician (PCP)

All In-Network Care must be received from your Primary Care Physician (PCP). A Participant may access specialty care directly from an In-Network Specialist Physician; no PCP Referral is needed.

Remember you—the Participant—must decide whether to have your care coordinated by your PCP, get care from a specialist who is a Network Provider without a Referral of get care from an Out-of-Network Provider at the "point of service". You will pay more if you get care from an Out-of-Network Provider.

PCPs are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a Participant becomes sick or is injured after the PCP's regular office hours, the Participant should:

- call the PCP's office; and
- identify himself or herself as a Participant; and
- follow the PCP's or covering Physician's instructions.

If the Participant's Injury or illness is a Medical Emergency, the Participant should follow the procedures outlined under the Medical Emergency Care section.

Payment terms apply to all Covered Services. The following services are covered, if Medically Necessary. Please refer to the **Summary of Benefits** for payment explanations.

Private Duty Nursing Services

Pre-certification of Medical Necessity is required from the Physician.

Limitations for both Inpatient and Outpatient RN and LPN

- Eligible Charges for services of an RN or LPN, whether on an Inpatient of outpatient basis, are limited to the calendar year maximum per Participant as shown in the Summary of Benefits.
- Inpatient care is covered only when no intensive or cardiac care unit is available, and the care needed is beyond the capabilities of the Hospital's floor nurses.
- Eligible Charges do not include services when:
  - Requested by, or for the convenience of, the patient or the patient's family;
  - Services consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving oral medication, or acting as a companion or sitter;
  - The private duty nurse is a relative by blood or marriage or member of the household of the Participant;
  - Inpatient services could have been rendered by the Hospital's general nursing staff; or
  - Outpatient services could be safely rendered by an individual other than a RN or LPN.

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from an Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

The following items related to prosthetic devices include artificial limbs and accessories, artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s), arm braces, leg braces (and attached shoes), and external breast prostheses used after breast removal.

The following items are **excluded:** corrective shoes; dentures; replacement of teeth or structures directly supporting teeth except to correct traumatic injuries; electrical or magnetic continence aids (either anal or urethral); hearing aids or hearing devices; or implants for cosmetic purposes except for reconstruction following a mastectomy.

Reconstructive Surgery

Pre-certification is required. Reconstructive Surgery does not include any service otherwise excluded in this Benefit Booklet. (See "Limitations and Exclusions".)

Reconstructive Surgery is covered only to the extent Medically Necessary:

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

Registered Nurse First Assistant

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

Second Medical Opinion

Covered Services include a second medical opinion by a Network Physician with respect to any proposed surgical intervention or, when pre-certified by the Claims Administrator, any medical care that is a Covered Service.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Summary of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the patient's residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Participant stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and Radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient;
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Participant reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for chronic brain syndromes for which specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Participant is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Specialist Physician

All In-Network primary care must be received from your Primary Care Physician. A Participant may access specialty care directly from a Specialist Physician; no PCP Referral is needed.

Treatment of Accidental Injury in a Physician's Office

All outpatient surgical procedures related to the treatment of an Accidental Injury, when provided by an In-Network Physician's office, will be covered under the Participant's Physician office Copayment. Services rendered by an Out-of-Network Physician's office are subject to Deductible and Coinsurance requirements.

Network Mental Health Care and Substance Abuse Treatment

Benefits are **not** credited toward the Out-of-Pocket Limit and are never paid at 100%.

Hospital Inpatient Care
Benefits for Inpatient Hospital and Physician charges are subject to the Deductible, Coinsurance requirements and may be limited as shown in the **Summary of Benefits**.

Professional Outpatient Care
Benefits for outpatient charges for each Participant (50-55 minute sessions or their equivalent) are stated in the **Summary of Benefits**.

Other Medical Care Covered Services include:
- Professional care in the outpatient department of a Hospital;
- Physician's office visits;
- Services within the lawful scope of practice of a licensed, approved Provider.

Note: To be reimbursable, care must be given by a psychiatrist, neuropsychologist, or a mid-level Provider such as a licensed clinical social worker, mental health clinical nurse specialist, a licensed marriage and family therapist, or a licensed professional counselor.

Mental Health Care or Substance Abuse Treatment may be obtained by calling 1-800-292-2879.

Limitations and Exclusions

Pre-existing Conditions

Until coverage for a Participant enrolled under this Plan has been in force for six consecutive months (Employee) or twelve consecutive months (Dependent), except for Maternity Care, benefits for services to be paid by this Plan shall not be available for any illness, Injury or other condition for which:

- Medical advice, diagnosis, care, or treatment was recommended or received within the previous six months preceding the Effective Date of coverage of an individual Participant.

What's Not Covered

Your coverage does not provide benefits for:

1. Care, supplies, or equipment not Medically Necessary, as determined by the Plan, for the treatment of an Injury or illness.
2. Services rendered or supplies provided before coverage begins, i.e., before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include, but not be limited to Inpatient Hospital admissions that begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.
3. Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
4. Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
5. Any portion of a provider's fee or charge which is ordinarily due from a Participant, but which has been waived. If a provider routinely waives (does not require the Participant to pay) a Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
6. Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. **Exception:** Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if elected by the Group and additional Premium is paid.
7. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
8. Any item, service, supply or care not specifically listed as a Covered Service in this Benefit Booklet.
9. Care given by a medical department or clinic run by your Employer.
10. Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
11. Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
12. Care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
13. Daily room charges while the Plan is paying for an Intensive Care, cardiac care, or other special care unit.
14. Vision care services and supplies, including, but not limited to eyeglasses, contact lenses, and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service.
15. Hearing aids, hearing devices and related or routine examinations and services.
16. Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Benefit Booklet.

17. The following items related to Durable Medical Equipment are specifically **excluded:**
    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Arch supports and orthopedic or corrective shoes;
    - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
    - Sterile water;
    - Deluxe equipment, such as motor driven chairs or beds, when standard equipment is adequate;
    - Rental or purchase of equipment if you are in a facility which provides such equipment;
    - Electric stair chairs or elevator chairs;
    - Physical fitness, exercise, or ultraviolet/tanning equipment;
    - Residential structural modification to facilitate the use of equipment;
    - Other items of equipment that do not meet the listed criteria.
18. Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.
19. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
20. Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
21. Care, supplies, or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.
22. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, unless treatment relating to such consequences is Medically Necessary. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary, is not covered.
    - This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
    - This exclusion does not apply to Breast Reconstructive Surgery. Please see the "Benefits" section of this Benefit Booklet.
23. Complications of non-covered procedures are not covered.
24. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this Benefit Booklet.
25. Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care providers as listed in this Benefit Booklet.
26. Except as may be provided in the "Benefits" section, any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition. Food supplements. Services of Inpatient treatment of bulimia, anorexia or other eating disorders that consist

primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical or psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Procedures including but not limited to liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw.

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

testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders) hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Neither physical nor occupational therapy is covered for Developmental Delay. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.

45. Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
    - the treatment is for maintenance therapy; or
    - the Participant has no restorative potential; or
    - the treatment is for congenital learning or neurological disability/disorder; or
    - the treatment is for communication training, educational training or vocational training.
46. Injuries received while committing a crime.
47. Biomicroscopy, field charting or aniseikonic investigation.
48. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
49. Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency (unless the Plan has mental health outpatient benefits) and (2) for the management of chronic, non-malignant pain and/or any off-label usage that does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.
50. Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.
51. Any drug or other item that does not require a prescription.
52. The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
    - Transportation, travel or lodging expenses for non-donor family members;
    - Donation related services or supplies, including search, associated with organ acquisition and procurement;
    - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
    - Any transplant not specifically listed as covered.
53. Acupuncture and acupuncture therapy.
54. Private room, except as specified as Covered Services.
55. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
56. Court-ordered services, or those required by court order as a condition of parole or probation.
57. Hypnotherapy.
58. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
59. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
60. Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
61. Thermograms and thermography.
62. Maternity benefits for a dependent child.
63. Charges for marital counseling.
64. Massage therapy, when not administered by a licensed physical therapist or physiotherapist.
65. Medical records in excess of $25.00.
66. Elective abortion.
67. Prescription Drugs obtained at a retail pharmacy or through a mail order facility. Coverage for prescriptions is offered through an independent vendor for Cobb County Government employees. Please refer to the appropriate summary of plan coverage for prescription drug details.

Coordination of Benefits (COB)

If you, your Spouse, or your Dependents have duplicate coverage under another group Plan, any other group medical expense coverage, or any local, state or governmental plan (except school accident insurance coverage or Medicaid), then benefits payable under this Plan will be coordinated with the benefits payable under the other plan. The Plan's liability in coordinating will not be more than 100% UCR or the contracted amount.

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

Order of Benefit Determination

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

- Automobile Insurance
  Medical benefits available through automobile insurance coverage will be determined before that of any other plan.
- Non-Dependent/Dependent
  The benefits of the plan which covers the person as an Employee (other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
- Dependent Child/Parents Not Separated or Divorced
  Except as stated below, when this Plan and another plan cover the same child as a Dependent of different persons, called **"parents"**:
  - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.
  - If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    However, if the other plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- Dependent Child/Parents Separated or Divorced
  If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the plan of the parent with custody of the child;
  - then, the plan of the Spouse of the parent with custody of the child; and
  - finally, the plan of the parent not having custody of the child.
- Medicare
  - Any benefits covered under both this Benefit Booklet and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Benefit Booklet provisions and federal law.
  - Except when federal law requires the Plan Sponsor to be the primary payor, the benefit under this Benefit Booklet for Participants age 65 and older, or Participants otherwise eligible for Medicare, do not duplicate any benefit for which Participants are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Participants shall be reimbursed by or on behalf of the Participants, to the extent the Claims Administrator has made payment for such services. For the purposes of the calculation of benefits, if the Participant has not enrolled in Medicare Part B, the Claims Administrator will calculate benefits as if they had enrolled.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply

with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the company has that actual knowledge.

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

Effects on the Benefits of this Program

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

Reduction in this Plan's Benefits

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

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

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

Miscellaneous Rights

- Right to Receive and Release Necessary Information
  Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to pay the claim.
- Facility of Payment
  A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.
- Right of Recovery
  If the amount of the payment made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:
  - the persons it has paid or for whom it has paid,
  - insurance companies, or
  - other organizations.

Subrogation

The Plan reserves the right to be reimbursed for benefits paid under this Plan if the person for whom benefits are paid has a right to recover these benefits from a third party. This is called **subrogation**. This provision helps control the cost of the Plan by limiting certain recoveries to the actual medical expense lost. The purpose of this provision is to help the Employer continue providing high-quality health care benefits. In no instance shall a Participant be asked to reimburse more than the actual medical expenses paid on his/her behalf.

Right of Subrogation

If a Participant incurs medical expenses as the result of injuries suffered because of the alleged negligence or misconduct of another person, the Participant may have a claim against that person for payment of medical bills. The Plan will be subrogated to the right of recovery the Participant has against the other person.

This right shall be only to the extent of benefits paid by the Plan for medical expenses. The Participant will be required to reimburse the Plan out of any monies the Participant receives from the other person or his or her insurance company as a result of judgment, settlement or otherwise. The Participant will be required to furnish to the Claims Administrator information and assistance required to enforce this right of subrogation. The right of subrogation shall not apply to any recovery a Participant obtains from any insurance company under which the Participant is the insured person.

Subrogation will be administrated by the Plan Administrator in coordination with the Claims Administrator. The Participant shall provide notice of the existence of a claim for recovery against a third party by certified mail to: Personnel Director, Cobb County Government, 100 Cherokee Street, Suite 350, Marietta, GA 30090-9679.

The purpose of this provision is to help provide insurance at reasonable rates.

Claims and General Information

How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 90 days after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for you.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, you must receive treatment from a Preferred Provider. When admitted to a Preferred Hospital, present your Identification Card. Upon discharge, you will be billed only for those charges not covered by the Plan. If you are admitted to a Non-Preferred Hospital that does have a Participating agreement with the Claims Administrator, inform the admitting personnel of your coverage. The Hospital will bill the Claims Administrator directly for Covered Services.

When you receive Covered Services from a Preferred Physician or other preferred licensed health care provider, ask him or her to complete a Physician's Service Report form. Payment for Covered Services will be made directly to the provider.

For health care expenses other than those billed by a Preferred Provider, use the Subscriber Health Expense Report (SHER) to report your expenses. You may obtain these from your Employer or the Claims Administrator. Claims should include your name, Plan and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for your records. The address is on the SHER claim form. Save all bills and statements related to your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Balance Billing

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

Processing Your Claim

You are responsible for submitting your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain you have your Identification Card with you. Be sure Hospital or Physician's office personnel copy your name, and identification numbers accurately when completing forms relating to your coverage.

If you are hospitalized outside Georgia, the claim for Hospital services is usually handled in the same manner as within the state and the Hospital files the claim through its local Blue Cross and Blue Shield office. It may, however, be necessary for you to pay the Physician for his services and then submit an itemized statement to the Claims Administrator office when you return home.

Timeliness of Filing

To receive benefits, a properly completed claim form with any necessary reports and records must be filed within 90 days of the date of service. The maximum time limit for filing is 12 months from the date of service.

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, the Claims Administrator will complete claims processing.

Necessary Information

In order to process your claim, the Claims Administrator may need information from the provider of the service. As a Participant, you agree to authorize the Physician, Hospital or other provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

Unauthorized Use of Identification Card

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

Questions About Coverage or Claims

If you have questions about your coverage, contact your Plan Administrator or the Claims Administrator's Customer Service Department. Be sure to always give your ID number. If you wish to get a full copy of the Utilization Review program procedures, contact the Claims Administrator's Customer Service Department.

Write

Customer Service Department
Blue Cross Blue Shield of Georgia, Inc.
P.O. Box 7368
Columbus, Georgia 31908

When asking about a claim, give the following information:

- Participant ID number;
- Patient name;
- Employee name and address;
- Date of service; type of service received; and
- Provider name and address (Hospital or Physician).

Right to Appeal

For all claims submitted by you or in your behalf, you will receive a notice (Explanation of Benefits) showing the amount charged; the amount paid by the Plan; and, if payment is partially or wholly denied, the reason.

If your claim is denied or if you have not heard anything within 60 days after providing proof of claim, you can appeal. Any legal action must be brought within three years after the date the services or supplies were provided.

Complaints about Service

As a Participant, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process established to ensure that your concerns are given the fullest attention.

- Call the Customer Service Department. The phone number is on your ID Card. Tell the representative your problem and he or she will work to resolve it for you as quickly as possible.
- If you are not satisfied with the answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
- If, depending on the nature of your complaint, you remain dissatisfied after receiving the response, you will be offered the right to appeal the decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will, hopefully, bring the matter to a satisfactory conclusion for you.

Complaints about Provider Service

If your complaint involves care received from a provider, please call the Customer Service number. Your complaint will be resolved in a timely manner.

Terms of Your Coverage

The Plan provides the benefits described in this Benefit Booklet only for eligible Participants. The health care services are subject to the limitations, exclusions, Copayments, and percentage payable requirements specified in this Benefit Booklet. Any group plant or certificate that you received previously will be replaced by this Plan.

Benefit payment for Covered Services or supplies will be made either directly to the Network Hospital (or Network Facility), the Network Physician or to you depending upon whether services were rendered by a Network or Non-Network Provider.

Neither the Plan nor the Claims Administrator is responsible for any Injuries or damages you may suffer due to actions of any Hospital, Physician or other person.

An oral explanation of your benefits by an Employee of the Claims Administrator, Plan Administrator, Plan Sponsor or Employer is not legally binding.

Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying the Plan and the Claims Administrator of you new address.

General Information

Fraudulent statements on Employee application forms and on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Participant's coverage.

The Plan Administrator and the Claims Administrator are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire etc.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Changes in Coverage

The Plan Sponsor may change the benefits described in this Benefit Booklet. The Participant will be informed of such a change as required by law

Acts Beyond Reasonable Control (Force Majeure)

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

Licensed Controlled Affiliate

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

Calculation of Coinsurance and Other Participant Liability

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:

- The billed charges for your Covered Services, or
- 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 that 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 specified 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 specified 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 to correct for over- or underestimation 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 your 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 any 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.

Care Received Outside the United States

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. All services will be subject to appropriateness of care. We will reimburse you directly. Payment will be based on Eligible Charges and based on the UCR of the Participant's legal residence (i. e., local UCR). Assignments of benefits to foreign providers or facilities cannot be honored.

When Coverage Terminates

Termination of Coverage

Membership for Participants may be continued as long as the Employee is employed by the Employer and meets eligibility requirements. It ceases if employment ends or if a Participant fails to make any required contribution toward the cost of coverage. In either instance, coverage would end at the expiration of the period covered by the Participant's last contribution. Coverage for a deceased Employee's covered dependents will continue for a period of 90 days from the date of death. *If the employee suffered a fatal injury by accident arising out of and in the course of his/her employment, his/her covered Spouse shall be entitled to continued coverage for a period of five years from the date of death. Covered dependent children shall continue coverage to the earlier of the date they last meet the eligibility requirements or until they attain age 19. Fatal injury will specifically exclude the following: injury caused by the willful act of a third person directed against an employee for reasons personal to such employee; a disease in any form; heart disease, heart attack, stroke, the failure or occlusion of any of the coronary blood vessels, or thrombosis; alcoholism or drug addition resulting in death.*

You must notify the County's benefit Plan Administrator within 30 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the Plan's definition of Dependent. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

Should you fail to notify the Plan Administrator within 60 days of your Dependent's loss of plan eligibility the County will, upon becoming aware of the situation, immediately cancel coverage for the dependent and, at its discretion, will take one of the following two actions:

1. Charge you the COBRA premium for the affected dependent for the period of coverage from the date of eligibility loss to the date the County became aware of the ineligible dependent, payable through payroll deduction, or
2. Retroactively deny coverage, including any claims incurred, to the date of eligibility loss.

Continuation of Coverage (Federal Law-COBRA)

If your coverage ends under the plan, you may be entitled to elect continuation coverage in accordance with federal law. If your employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct, instead of the three months continuation benefit described above, you may elect from 18-36 months of continuation benefits.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Employee during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
For Spouses/ Dependents: A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Employee's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months
For Dependents: Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

If you are a retiree under this plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event
If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), your Spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Spouse or dependent children to lose coverage under the plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements
In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your employer must notify the company benefit Plan Administrator within 30 days. You must notify the company benefit Plan Administrator within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Continuation of Coverage (Federal Law – USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Participant may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 30 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the Group terminates all of its group welfare benefit plans.

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the group's health plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active employees can remain on the group's health plan and receive group benefits as primary coverage.

Questions regarding Medicare eligibility and enrollment should be directed to your local Social Security Administration office.

Definitions

Accidental Injury
Bodily Injury sustained by a Participant as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Participant receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Applicant
The corporation, partnership, sole proprietorship, other organization or group which applied for this Plan.

Application for Enrollment
The original and any subsequent forms completed and signed by the Subscriber seeking coverage. Such Application may take the form of an electronic submission.

Benefit Period
One year, January 1 – December 31 (also called year or calendar year). It does not begin before a Participant's Effective Date. It does not continue after a Participant's coverage ends.

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

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

Claims Administrator
The company the Plan Sponsor chose to administer its health benefits. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. was chosen to administer this Plan.

Coinsurance
If a Participant's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Participant is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Limit. Compare to Copayment.

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

Complications of Pregnancy
Complications of pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but, are adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy that is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

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

Contract Year
A period of one year commencing on the Effective Date (or renewal date) and ending at 12:00 midnight on the last day of the one year period.

Coordination of Benefits
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claim payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

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

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

Covered Dependent
Any Dependent in an Employee's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the BlueChoice Healthcare Plan, and is subject to Premium requirements set forth in this Plan

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

Custodial Care
Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Participant has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Participant's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Participant, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of BCBSHP can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible
The portion of the bill you must pay before your medical expenses become Eligible Charges. It usually is applied on a calendar year basis.

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

Children who are full-time students (after high school) in an institution of higher learning at least five months each year remain covered up to and including age 25. Children up to and including age 25 that were required to withdraw enrollment from a post-secondary institution, prevented from enrollment, or required to reduce enrollment below the level required for full-time status as a result of an injury or illness shall be entitled to the same benefits as if the Dependent continued to be enrolled as a full-time student. Mentally retarded or physically handicapped children remain covered no matter what age. You must give the Claims Administrator evidence of your child's incapacity within 31 days of attainment of age 19. The certification form may be obtained from the Claims Administrator or your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 19 or older at the time coverage is effective

Detoxification
The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay
The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury. Services rendered should be to treat or promote recovery of the specific functional deficits identified.

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

Effective Date
The date the Plan approves an individual application for coverage. For individuals who join this Group after the first enrollment period, the Effective Date is the date the Plan approves each future Participant according to its normal procedures.

Elective Surgical Procedure
A surgical procedure that is not considered to be an emergency, and may be delayed by the Participant to a later point in time.

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

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

Employee
A person who is engaged in active employment with the Group and is eligible for Plan coverage under the employment regulations of the Employer.

Employer
An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

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

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961(t)(2) of the Social Security Act;
- The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institute of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any National board recognized by the National Institutes of Health for the purpose of evaluating the medical value of heath services; or
- It meets the Technology Assessment Criteria as outlined in the Definitions Section of this Benefit Booklet.

Freestanding Ambulatory Facility (Surgi-Center)

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed by the appropriate state agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Health Plan Document

This Benefit Booklet in conjunction with the Plan, the Application, if any, any amendment or rider, your Identification Card and your Application for Enrollment constitutes the entire Plan. If there is any conflict between this Benefit Booklet or the Plan and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Plan, the Plan shall control.

Home Health Care

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

Home Health Care Agency

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

Hospice

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

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Participant and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate state agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

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

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

Identification Card
The latest card given to you showing your identification number and group number, the type of coverage you have and the date the coverage became effective.

Ineligible Charges
Charges for health care services that are not Eligible Charges because the services are not Medically Necessary or pre-admission certification was not obtained. Such charges are not eligible for payment.

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

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

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

Initial Enrollee
A person actively employed by the Employer (or one of that person's eligible Dependents) on the original Effective Date of the Health Plan Document between BCBSGA and the Employer or currently enrolled through the Employer under a BCBSGA contract.

Injury
Bodily harm from a non-occupational accident.

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

Intensive Care Unit
A special unit of a Hospital that: 1. treats patients with serious illnesses or Injuries; 2. can provide special life-saving methods and equipment; 3. admits patients without regard to prognosis; and 4. provides constant observation of patients by a specially trained nursing staff.

Late Enrollees
Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/hers initial enrollment period under the Plan: (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor covered Dependent under a Participant's Plan, but only as long as the Participant requests enrollment for such Dependent within thirty-one (30) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Claims Administrator that coverage was declined because other coverage existed.

Lifetime Maximum Benefit
The Lifetime Maximum Benefit includes all payments made under this and previous Plans with the Claims Administrator, its affiliates, successors and assigns, which this Plan replaces, amends, extends or succeeds. All services and all calendar year maximums—whether for a number of days or visits, treatments or a yearly dollar limit—are subject to the Lifetime Maximum Benefit.

Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Participant under the Plan.

MCSO-Medical Child Support Order
An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:
- provides for child support payment related to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

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

Medical Facility
Any Hospital, ambulatory care facility, chemical dependency facility, skilled nursing care facility, home health agency or mental health facility, as defined in this Benefit Booklet. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

Medical Necessity or Medically Necessary
The Plan Administrator reserve the right to determine whether a service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary.

The Plan Administrator consider a service Medically Necessary if it is:
- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the doctor, health care provider or Hospital;
- not primarily Custodial Care; and
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

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

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

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

New Hire
A person not employed by the Employer on the original Effective Date of the Plan.

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

Non-Participating Provider
A Hospital, Physician, Freestanding Ambulatory Facility (Surgi-Center), Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have a Participating Agreement with the Claims Administrator to provide services to its Participants at the time services are rendered.

Out-of-Area Urgent Care
Covered Services required in order to prevent serious deterioration of a Participant's health that results from an unforeseen illness or Injury if the Participant is temporarily absent from the BCBSHP Service Area and receipt of the health care service cannot be delayed until the Participant's return to the Service Area.

Out-of-Network Provider
A Hospital, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies, that does not have a Network Provider contract with the Claims Administrator. This provider may also be referred to as a Non-Network Provider.

Out-of-Pocket Limit
The maximum amount of a Participant's Coinsurance payments during a given calendar year. Such amount does not include Deductible and Copayment amounts or fees in excess of Providers' reasonable fees. When the Out-of-Pocket Limit is reached, the level of benefits is increased to 100% of Eligible Charges for Covered Services, exclusive of Copayments and other scheduled fees.

Participant
The Subscriber and each Dependent, as defined in this Benefit booklet, while such person is covered by this Plan.

Participating Hospital
A Hospital located in Georgia which is a party to a written agreement with, and in a form approved by, Blue Cross Blue Shield of Georgia, Inc.; or a Hospital outside of Georgia which is a party to an agreement with another Blue Cross and Blue Shield Plan; or a Hospital outside Georgia located in an area not served by any Blue Cross and Blue Shield Plan.

Participating Provider
A Hospital, Physician, Freestanding Ambulatory Facility, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies that has signed a Participating Agreement with BCBSGA to accept its determination of Usual, Customary and Reasonable Fees (UCR) or other payment provisions for Covered Services rendered to a Participant who is his or her patient.

Periodic Health Assessment
A medical examination that provides for age-specific preventive services that improve the health and well- being of a patient being examined. This examination is provided through the network by Primary Care Physicians. The frequency and content of the health assessment are determined by established guidelines and the Participant's personal history.

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

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor or Osteopathy (D.O) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (Ph.D) are also providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Physician Assistant (PA)
An individual duly licensed by the State of Georgia to provide basic medical services under the supervision of a licensed Physician.

Physician Assistant Anesthetist (PAA)
An individual duly licensed by the State of Georgia to provide anesthesia services under the supervision of a licensed Physician specializing in anesthesia.

Plan
The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Plan Sponsor's health benefits.

Plan Administrator
The person named by the Plan Sponsor to manage the Plan and answer questions about Plan details.

Plan Sponsor
The legal entity that has adopted the Plan and has authority regarding its operations, amendments and terminations.

Plan Year
A period of one year commencing on the Effective Date (or renewal date) and ending at 12:00 midnight on the last day of the one year period.

Premium
The amount that the Group or Participant is required to pay the Claims Administrator to continue coverage.

Primary Care Physician (PCP)
A licensed Physician who is a Participating Provider trained in general family practice, pediatrics or internal medicine, and has entered into an agreement to coordinate the care of Participants. Your Primary Care Physician provides initial care and basic medical services, assists you in obtaining pre-certification of Medically Necessary Referrals for Specialist and Hospital care, and provides you with continuity of care.

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

Psychiatric Services within a General Hospital Facility
A general Hospital facility that provides Inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a Physician.

QMCSO – Qualified Medical Child Support Order
A QMCSO creates or recognizes a right of a child who is recognized under the order as having the right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the Plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each plan to which the order applies.

Reimbursement Rate
The percentage of Eligible Charges calculated each year by the Claims Administrator and BCBSGA for any In-Network or Participating Hospital. The payment rate will be applied to all Hospital Inpatient and outpatient claims during the payment period, including Out-of-Network and Non-Participating Hosptials.

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

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

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

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

Spinal Manipulation
Correction of subluxations in the body to remove nerve interference or its effects. Interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Sponsor
Cobb County Government

Spouse
For the purpose of this Plan, a Spouse is defined as a person who is married to a person of the opposite sex from that of the enrolling Employee.

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

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

Substance Abuse Residential Treatment Center
A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and Group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Technology Assessment Criteria
Five criteria all procedures must meet in order to be Covered Services under this Plan.
- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternative.
- The technology must be beneficial in practice.

Usual-Customary-Reasonable (UCR) Fees (as determined by the Claims Administrator and approved by the Plan)
Customary Fee: Based on a competitive profile of the usual fees received as reimbursement by similar Physicians in a given geographic area for the procedure performed, according to BCBSHP's records.

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

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

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

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

You and your
Refer to the Employee, Participant and each Covered Dependent.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate lifetime limits, calendar year dollar limits, and treatment limitations (day or visit limits) on mental health and substance abuse benefits with dollar limits or day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set calendar year dollar limits, lifetime dollar limits, or day/visit limits on mental health or substance abuse benefits that are lower than any such dollar limits or day/visit limits for medical and surgical benefits. A plan that does not impose calendar year dollar limits, lifetime dollar limits, or day/visit limits on medical and surgical benefits may not impose such dollar limits or day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. **See the Summary of Benefits.**

If you would like more information on WHCRA benefits, call your Plan Administrator.

RESOLUTION

Be it resolved and it is hereby resolved that:

- Cobb County, Georgia has a medical benefit plan for its Employees known as the Cobb County Government Employee Health Benefit Plan. The Plan Administrator is Blue Cross and Blue Shield of Georgia whose address is 3350 Peachtree Road, NE, 14th Floor, Atlanta, Georgia 30326; and
- The Health Benefit Plan is fully self-funded; and
- Cobb County elects to opt out of all the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), the 48 hour/ 96 hour minimum length-of-stay law for childbirth, the Mental Health Parity Act, which would otherwise apply under the PHS Act; and
- Cobb County may voluntarily choose to provide the same coverage and related rights pursuant to its independent authority;

Therefore, it is hereby resolved that Cobb County elects to opt out of all of the provisions of HIPAA (except for the duty to provide coverage certificates to employees and dependents whose plan coverage ends), the 48 hour/96 hour minimum length-of-stay law for childbirth, and the Mental Health Parity Act, which would otherwise apply under the PHS Act. The County reserves its right to provide the same and/or similar coverage and related rights pursuant to its own authority.

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