BlueCross BlueShield of Georgia

Georgia Child-Only Health Insurance PPO Assignment Plan
Summary of Benefits

Schedule of benefits	Plan A
Lifetime maximum The most (COMPANY) will pay for the costs of non-emergency services over the course of your life.	Unlimited
Calendar year deductible The amount you must pay each year for coverage before (COMPANY) has an obligation to pay any amount.	In network: $2,500 Out of network: $2,500 In network and out of network charges accumulate to same deductible.
Percentage you pay after deductible is met	30% up to $3,000 maximum
Percentage you pay for office visits and outpatient treatment of accident injury	30%
Out of pocket maximum (Individual) The maximum you pay each year including deductible	In network: $5,500 Out of network: $5,500
Treatment for inpatient mental health disorders	30 day limit for inpatient mental health treatment; no coverage for outpatient treatment, in network and out of network combined.
Hospital inpatient care	Includes semi-private room, intensive care and cardiac care services and supplies and other hospital services.
Pre-admission certification	Pre-admission certification is required for all hospital admissions. Emergency or maternity care admissions must be certified within 48 hours. A $500.00 penalty may apply if you are hospitalized and pre-admission has not been obtained.
Length of stay	Unlimited as long as medically necessary.
Hospice care	Benefits are provided for inpatient and outpatient hospice care.
Outpatient surgery	Covered subject to deductible and coinsurance.
Preventive care service	Covered 100%, not subject to deductible. Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, and more.
Maternity	Covered as any other illness.
Prescription drugs	Covered subject to deductible and coinsurance.

Limitations and exclusions

1. Temporomandibular joint syndrome (TMJ) is limited to 15 visits per Member per calendar year.
2. Physical, Occupational, Chiropractic Therapy is limited to 30 visits per calendar year
3. Skilled Nursing Facility Care is limited to 30 days per calendar year
4. Speech Therapy Services is limited to 30 visits per calendar year
5. Respiratory Therapy, Radiation Therapy, Chemotherapy Services is limited to 30 visits per calendar year
6. Home Health Care Services is limited to 60 visits per calendar year
7. Inpatient hospital admissions which begin before a Member's effective date. No benefits are payable if you are confined in an Ineligible Hospital.
8. Care for any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.
9. Any disease or injury resulting from a war, declared or not, or any military duty. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities as required by law.
10. Any item, service, supply or care not specifically listed as a benefit in this Contract.
11. Care given by a medical department or clinic run by your employer.
12. Admission or continued hospital or skilled nursing facility stay for medical care or diagnostic studies not medically required on an inpatient basis.
13. Foot inserts; care of corns, bunions (except capsular or related surgery), callouses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot), flat feel, fallen arches, weak feet, chronic foot strain, or symptomatic complaints related to the feet.
14. Daily room charges while the Contract is paying for an intensive care, cardiac care, or other special care unit.
15. Eyeglasses, contact lenses, hearing aids, hearing devices and related examinations and services.
16. Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs.
17. Custodial care, rest cures, or travel expenses even if recommended for health reasons by a physician. Transportation to another area for medical care is also excluded except when medically necessary for you to be moved by ambulance from one hospital to another.
18. Care, supplies or equipment not medically necessary for the treatment of injury or illness. Non-covered supplies are inclusive of but not limited to: band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards.
19. Cosmetic or reconstructive surgery except to restore function of any body area altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes. Complications of non-covered procedures are not covered.
20. 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; alveloplasties, dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this Contract.
21. Surgical or medical care for obesity, weight reduction, or dietary control except as related to covered nutritional counseling. Services, supplies and/or nutritional sustenance products (food) related to enteral feeding. Services for inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and educational services.

22. Surgical or medical treatment to modify the sex (transsexualism) or services related to treatment for impotency (except organic) or other sexual dysfunctions or inadequacies.
23. Transportation provided by other than a state licensed professional ambulance service.
24. Hair transplants, hair pieces or wigs, wig maintenance or prescriptions or medications related to hair growth.
25. Advice or consultation given by any form of telecommunication.
26. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in Blue Cross and Blue Shield of Georgia's judgment, experimental or investigational for the diagnosis for which the Member being treated are excluded. Services which support or are performed in connection with the experimental or investigational services are also excluded.
27. Care for which you have no legal obligation to pay or for which no charge would be made if you had no health insurance coverage.
28. Charges for failure to keep a schedule visit or for completion of claim forms; for physician or hospital's stand- by services; for holiday or overtime rates.
29. 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.
30. Services for outpatient therapy other than those specifically listed in this Contract.
31. Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism.
32. Treatment where payment is made by any local, state or federal government (except Medicaid).
33. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits.
34. Services related to or performed in conjunction with artificial insemination, in vitro fertilization, reverse sterilization, or combination thereof.
35. Biofeedback, recreational, or educational therapy or other forms of self-care or self-help training and any related diagnostic testing.
36. Inpatient hospital care for mental health conditions when the stay is:
    - Determined to be court-ordered, custodial, or solely for the purpose of environment control;
    - Rendered in a home, halfway house, school or domiciliary institution;
    - Associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related to marital, social, cultural or work situations; and
    - Incurred through participation in day/night and/or partial hospitalization programs.
37. Services for conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation.
38. Inpatient rehabilitation in the hospital or hospital-based rehabilitation facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a physician or:
    - The treatment is for maintenance therapy;
    - The Member has no restorative potential;
    - The treatment is for congenital learning or neurological disability/disorder; or
    - The treatment is for communication training, educational training or vocational training.
39. Suicide or attempted suicide and intentionally self-inflicting injuries or poisoning.
40. Injuries received while committing a crime.

41. 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, artificial organ transplants or mechanical organ transplants;
    - Transportation, travel or lodging expenses for non-donor family members;
    - Donation related services or supplies provided to a covered donor if the recipient is not covered under this Contract and eligible for transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue;
    - Chemotherapy with autologous, allogenic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
    - Any transplant not specifically listed as covered.
42. Any portion of a provider's fee or charge which is ordinarily due from a Member but which has been waived. If a provider routinely waives (does not require the Member to pay) a Deductible or Out-of-Pocket amount, BCBSGA will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
43. Care prescribed and supervised by someone other than a physician unless performed by other licensed health care providers as listed in this contract.
44. Services that are 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.
45. Expenses in excess of the usual, customary, and reasonable charges (as determined by BCBSGA).
46. Outpatient care for nervous and mental disorders, and substance abuse.
47. This coverage pays for eligible expenses after any group health plan has paid. In no case shall the total payment of this health care coverage and other coverage exceed 100% of the eligible charges. Eligible expenses which are reimbursed by any group health care plan are not covered by this Contract.
48. Your benefits will be reduced if you are eligible for coverage (even if you did not enroll) under any federal, state (except Medicaid) or local government health care program. Such coverage includes Medicare Part A and B and other similar programs. This reduction in payment will be equal to the amount that was paid or would have been paid (if you had been enrolled) by the other program.

Access to the Medical Information Bureau (MIB)

Information regarding your insurability will be treated as confidential. Blue Cross Blue Shield of Georgia or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 886-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is:
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Information for consumers about MIB may be obtained on its website at mib.com.

Blue Cross Blue Shield of Georgia, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below.

The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review/Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite. Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

To view a Summary of Benefits and Coverage please visit healthcare.gov.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Blue Cross and Blue Shield of Georgia, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.