Coverage Details

Things you need to know before you buy.

BlueCross BlueShield of Georgia

Georgia Child-Only Health Insurance PPO Assignment Plan (Children under 19 years of age)

Before you choose a health care plan, please read this, along with the other materials enclosed.

Enrollment guidelines for Individual health plans

Enrollees **must:**

- Be under 19 years of age.
- Be a permanent legal resident of Georgia.
- Not be eligible for or enrolled in other coverage (includes enrollment in a high-risk pool plan).

Open enrollment

The open enrollment period will be January 1-31, 2013. Policy coverage begins March 1, 2013. We must receive your application during the open enrollment period.

Special enrollment

Blue Cross and Blue Shield of Georgia will accept special enrollment applications for Child-Only plans (children under age 19) if:

- You notify us within 60 days of a qualifying event.
- We receive your application within 30 days of the date you notify us.

Qualifying events include:

- Loss of employer-sponsored health insurance coverage
- Involuntary loss of other existing coverage for any reason other than fraud, misrepresentation or failure to pay premium
- Loss of health insurance coverage due to a dissolution of marriage
- Marriage
- Entry of a valid court or administrative order that requires that the applicant be covered under a health insurance policy
- Adoption
- Birth

The special enrollment period for qualifying events will be open for 30 days from the date we receive notice of the qualifying event.

Surcharge

Child-only applicants who do not have creditable coverage within the 63 days preceding the application date will be assessed a surcharge of 50%, billed as a part of the monthly premium. **Because of the impact to your rate, it is important to provide prior coverage information on your application if you had prior coverage.**

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 needed for all elective inpatient admissions and certain outpatient care. It considers need (medical necessity), the best level of care and 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.

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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.

Benefits that are not covered by this Individual health care plan

Remember, all health care plans are different and, as with many plans, there are some exclusions. To choose the plan that best meets your needs, it's important to understand not only what it offers, but what is does not.

Your contract does not provide benefits for:

- Services and supplies not medically necessary or not consistent with the diagnosis
- Treatment for which payment is made by any local, state or federal government (except Medicaid)
- Services paid under Medicare or the Veterans Administration
- Any injury or disease related to war, declared or undeclared, or military service; Convalescent or custodial care
- Hair transplants
- Eyeglasses/contact lenses/radial keratotomy and the examinations associated with them
- Hearing aids
- Experimental services
- Weight reduction or treatment for obesity
- Physical, occupational or speech therapy for developmental delay
- Services related to artificial insemination or in-vitro fertilization
- Cosmetic services, except as otherwise stated in the contract

In addition, dental care and treatment and oral surgery are not covered. A full disclosure of all benefits, exclusions and limitations is included in the Contract for this coverage or any optional coverage amendments. Please review these carefully upon enrollment.

This is not your policy and is intended as Coverage Details only. If there is any difference between this brochure and the policy Contract booklet, the provisions of the Contract booklet shall prevail.

These Coverage Details comply 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 these Coverage Details.

Georgia Child-Only Health Insurance PPO Assignment Plan
Effective 1/1/2013

(Without optional Mental Health Rider)

CHILD AGE	Male	Female
0-18	$192	$216

(With optional Mental Health Rider)

CHILD AGE	Male	Female
0-18	$253	$277

Choosing a health care plan is important.

That's why we offer these support materials:

- Summary of Benefits
- Coverage Details
- Enrollment Application

If you're missing any of these, please call your Blue Cross and Blue Shield of Georgia agent.

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