

THE INDEMNITY HEALTH BENEFITS PLAN



“Creating A More Educated Georgia”

THE UNIVERSITY SYSTEM OF GEORGIA

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

RESOURCE CONTACTS

Should you have questions regarding your indemnity health benefits plan, please contact the appropriate resource(s) identified below:

| For Questions About: | Please Contact | Location |
|--|--|--|
| Claims/Coverage Provided by the Plan | Campus Human Resources/ Personnel Office Blue Cross Blue Shield of Georgia | Your Institution 1-800-424-8950 TDD/404-842-8073 |
| Participating Providers For information regarding the Participating providers in: (1) the BCBSGA Participating Physician Network (within the State of Georgia) Or (2) the BCBS National Participating Provider Network (outside the State of Georgia) | Blue Cross Blue Shield of Georgia Blue Cross Blue Shield Association - Customer Service | 1-800-675-6492 TDD/1-800-255-0056 (text) TDD/1-800-255-0135 (voice) |
| BCBSGa Online Tools and Online Provider Directory | Blue Cross Blue Shield of Georgia | www.bcbsga.com or www.bcbsga.com/bor |
| Pre-certification for Specific Outpatient/All Inpatient Hospital Services | BCBSGa | 1-800-233-5765 TDD/1-800-368-4424 |
| 24/7 Nurseline For emergency room referral and for medical information from a registered nurse, 24-hours a day, seven days a week. | BCBSGa | 1-800-785-0006 TDD/1-800-368-4424 |
| 360° Health Program | BCBSGa | 1-800-785-0006 TDD/1-800-368-4424 |
| Centers of Excellence Transplant Program | BCBSGa | 1-866-694-0724 TDD/1-800-368-4424 |
| Pharmacy Benefit Program | Medco | 1-877-300-5139 TDD/1-800-759-1089 |
| HIPAA Coverage | Secretary | U.S. Dept. of Health and Human Services Office of Civil Rights, Region IV 61 Forsyth St. SW, Suite 3B70 Atlanta, GA 30303-8909 404-562-7886 (metro Atlanta) 1-866-627-7748 (outside of metro Atlanta) |

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

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

BOR Indemnity Health Benefits Plan Summary Document

YOUR INDEMNITY HEALTH BENEFITS PLAN

INTRODUCTION

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

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

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

BENEFITS AT A GLANCE

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

| SELECTED PLAN FEATURES AND COVERED SERVICES | PLAN PROVISIONS AND BENEFITS |
|---|--|
| <p><u>Maximum Lifetime Benefits</u> <i>(Medical & Pharmacy Benefits Combined)</i></p> | <p>\$2 Million</p> |
| <p><u>Annual Deductible</u></p> <ul style="list-style-type: none"> • Individual • Family | <p>\$300 \$900</p> |
| <p><u>Maximum Annual Out-of-Pocket Limit (Stop Loss)</u></p> <ul style="list-style-type: none"> • Individual • Family <p><i>Annual deductibles, annual maximum out-of-pocket limits (stop loss), and annual visit limitations, will be based upon a January 1 - December 31 plan year.</i></p> | <p>\$2,000 \$4,000</p> <p>Member <i>co-payments</i> for prescription drugs <i>do not</i> apply toward the annual deductible or toward the maximum annual out-of-pocket (stop loss) limit.</p> <p>Member costs incurred for <i>balance billing</i> will <i>not apply</i> toward the annual deductible or toward the maximum annual out-of-pocket (stop loss) limit.</p> |
| <p><u>Pre-Existing Conditions</u></p> | <p>None</p> |
| <p><u>Physician Services Provided In An Office Setting</u></p> <ul style="list-style-type: none"> • Physician Office Visit <p><i>For treatment of illness or injury</i></p> | <p>80% of eligible charges for <i>non-surgical</i> services; <i>subject to deductible.</i></p> |
| <ul style="list-style-type: none"> • Wellness Care/Preventive Healthcare <p><i>Physical Exam, Mammogram, Pap Smear, Prostate Exam/PSA, Well-baby Care and Immunizations, Adult Immunizations, Routine Eye Exams, Routine Hearing Exams</i></p> | <p>\$750 per person per plan year; paid at 100% of eligible charges; <i>not subject to deductible.</i></p> <p>The maximum wellness benefit that a covered member may receive is \$750 per person per plan year, regardless of the network affiliation of the provider.</p> |

| SELECTED PLAN FEATURES AND COVERED SERVICES | PLAN PROVISIONS AND BENEFITS |
|---|---|
| <ul style="list-style-type: none"> • Laboratory Services <i>(Exclusive of Wellness Care/Preventive Healthcare)</i> <i>Laboratory, X-ray, Allergy Testing, Injectable Medications, and Diagnostic Tests</i> <i>Injectable medications that are provided in a physician's office may be covered under medical benefits.</i> <i>Pre-certification for diagnostic testing may be required.</i> | 80% of eligible charges; <i>subject to deductible.</i> |
| <ul style="list-style-type: none"> • Maternity Care <i>(Prenatal, Delivery and Postnatal)</i> | 90% of eligible charges when billed global; <i>subject to deductible. (services that are billed separately will be reimbursed at 80%)</i> |
| <ul style="list-style-type: none"> • Outpatient Surgery <i>Pre-certification may be required.</i> | 90% of eligible charges; <i>subject to deductible.</i> |
| <ul style="list-style-type: none"> • Second Surgical Opinions <i>(Elective Surgery)</i> | 100% of eligible charges; <i>not subject to deductible.</i> |
| <ul style="list-style-type: none"> • Allergy Testing, Shots and Serum | 80% of eligible charges; <i>subject to deductible.</i> |
| <ul style="list-style-type: none"> • Treatment of TMJ <i>(Temporomandibular Joint Disorders)</i> <i>For diagnostic testing & non-surgical treatment</i> <i>Pre-certification may be require.</i> | 80% of eligible charges; <i>subject to deductible.</i> Lifetime benefit limit of \$1,000. |

| SELECTED PLAN FEATURES AND COVERED SERVICES | PLAN PROVISIONS AND BENEFITS |
|---|---|
| <p><u><i>Inpatient Hospital Services</i></u></p> <ul style="list-style-type: none"> • Physician Services Physician Care/Surgery <p><i>Physician services may include surgery, anesthesiology, pathology, radiology, and/or maternity care/delivery.</i></p> <p><i>Pre-certification is required.</i></p> | <p>90% of eligible charges for surgeon, <i>subject to deductible.</i></p> <p>80% of eligible charges for anesthesiologist, pathologist, or radiologist services/consultations; <i>subject to deductible.</i></p> <p>Some <i>surgeons</i> and/or some <i>hospital-based</i> physicians (examples: emergency room physicians, anesthesiologists, pathologists and/or radiologists) providing services may not be part of the BCBSGa Participating Physician Program/BCBS National Participating Provider Network.</p> <p><i>Failure to access these BCBS programs or networks will result in the member being subject to balance billing.</i></p> |
| <ul style="list-style-type: none"> • Hospital Services Other Than Those For Emergency Room Care <p><i>Inpatient Care (Includes inpatient short term rehabilitation services)</i></p> <p><i>Pre-certification is required.</i></p> | <p><u><i>In-State Hospitals</i></u></p> <p>90% of eligible charges; limited to semi-private room rate; <i>subject to deductible.</i></p> <p><u><i>Out-of-State Hospitals</i></u></p> <p>90% of eligible charges for service area; limited to semi-private room rate; <i>subject to deductible.</i></p> <p>The use of a non-BCBS National Participating Provider Network facility, <i>outside of Georgia</i>, will result in benefit coverage at 90% of eligible charges; <i>subject to deductible and balance billing.</i></p> |
| <ul style="list-style-type: none"> • Maternity Care (Delivery) | <p>90% of eligible charges; <i>subject to deductible.</i></p> |

| SELECTED PLAN FEATURES AND COVERED SERVICES | PLAN PROVISIONS AND BENEFITS |
|--|--|
| <ul style="list-style-type: none"> • Laboratory Services <i>X-ray, Laboratory Work, Diagnostic Testing. Provided in conjunction with the treatment of an illness or injury.</i> <i>Pre-certification for diagnostic testing may be required.</i> | <p>90% of eligible charges; subject to deductible. (If independent Laboratory submits claim, 80% of UCR charges; subject to deductible.)</p> |
| <ul style="list-style-type: none"> • Hospice Care <i>Pre-certification is required.</i> | <p>90% of eligible charges; subject to deductible.</p> |
| <ul style="list-style-type: none"> • Treatment of TMJ (Temporomandibular Joint Disorders) <i>Surgical treatment</i> <i>Pre-certification may be required.</i> | <p>90% of eligible charges; subject to deductible.</p> |
| <p><u>Outpatient Hospital/Facility Services</u></p> <ul style="list-style-type: none"> • Physician Services Physician Care/Surgery <i>Physician services may include surgery, anesthesiology, pathology, radiology, and/or maternity care.</i> <i>Pre-certification may be required.</i> | <p>90% of eligible charges for surgeon; subject to deductible.</p> <p>80% of eligible charges for anesthesiologist, pathologist, or radiologist services/consultations; subject to deductible.</p> <p>Some <i>surgeons</i> and/or some <i>hospital-based</i> physicians (examples: emergency room physicians, anesthesiologists, pathologists and/or radiologists) providing services may not be a part of the BCBSGa Participating Physician Program/BCBS National Participating Provider Network.</p> <p><i>Failure to access these BCBS programs or networks will result in the member being subject to balance billing.</i></p> |

| SELECTED PLAN FEATURES AND COVERED SERVICES | PLAN PROVISIONS AND BENEFITS |
|--|---|
| <ul style="list-style-type: none"> • Facility Selected by a Treating Physician which is a Plan Approved Facility <p><i>Treatment/care provided in an outpatient setting may require pre-certification.</i></p> | <p>90% of eligible charges in a <i>Plan-approved facility; subject to deductible.</i></p> <p><i>Failure to use a Plan-approved facility will result in the member being subject to balance billing.</i></p> <p>For identification of a Plan-approved facility, <i>within the State of Georgia</i>, please contact BCBSGa Customer Services at 1-800-424-8950/TDD 404-842-8073.</p> <p>For identification of a Plan-approved facility, <i>outside the State of Georgia</i>, please contact BCBS Customer Service at 1-800-810-BLUE (2583).</p> |
| <ul style="list-style-type: none"> • Care in a Hospital Emergency Room (ER) <p><i>For treatment of an emergency medical condition or injury</i></p> | <p><u><i>Surgical Services:</i></u> 90% of eligible charges, <i>if referred by 24/7 Nurseline; subject to deductible.</i></p> <p>80% of eligible charges, <i>if not referred by 24/7 Nurseline; subject to deductible.</i></p> <p><u><i>Non-Surgical Services:</i></u> 80% of eligible charges, <i>if referred by 24/7 Nurseline; subject to deductible.</i></p> <p>70% of eligible charges, <i>if not referred by 24/7 Nurseline; subject to deductible.</i></p> |
| <ul style="list-style-type: none"> • Laboratory Services <p><i>X-ray, Laboratory Work, Diagnostic Testing. Provided in conjunction with treatment of an illness or injury.</i></p> <p><i>Pre-certification for diagnostic testing may be required.</i></p> | <p>80% of eligible charges; <i>subject to deductible.</i></p> |

| SELECTED PLAN FEATURES AND COVERED SERVICES | PLAN PROVISIONS AND BENEFITS |
|---|--|
| <ul style="list-style-type: none"> • Urgent Care Services | 80% of eligible charges; <i>subject to deductible.</i> |
| <ul style="list-style-type: none"> • Home Nursing Care <i>Pre-certification is required.</i> | 90% of eligible charges; <i>subject to deductible.</i> No plan year limit. |
| <ul style="list-style-type: none"> • Extended Care Facility <i>Pre-certification is required.</i> | 90% of eligible charges; <i>subject to deductible.</i> |
| <ul style="list-style-type: none"> • Home Hyperalimentation <i>Pre-certification is required.</i> | 90% of eligible charges; <i>subject to deductible.</i> No lifetime benefit limit. |
| <ul style="list-style-type: none"> • Hospice Care <i>Pre-certification is required.</i> | 90% of eligible charges; <i>subject to deductible.</i> |
| <ul style="list-style-type: none"> • Cochlear Implants <i>Pre-certification is required.</i> | 90% of eligible charges; <i>subject to deductible.</i> |
| <ul style="list-style-type: none"> • Ambulance Services <i>Land or air ambulance for medically necessary emergency transportation only</i> | 80% of eligible charges; <i>subject to deductible; subject to balance billing for non-participating/non-covered providers of ambulance services.</i> |
| <ul style="list-style-type: none"> • Durable Medical Equipment (DME) <i>Rental or Purchase</i> <i>Plan may require approved Letter of Medical Necessity and pre-certification may be required.</i> | 80% of eligible charges; <i>subject to deductible.</i> |

| SELECTED PLAN FEATURES AND COVERED SERVICES | PLAN PROVISIONS AND BENEFITS |
|--|---|
| <ul style="list-style-type: none"> • Outpatient Short Term Rehabilitation Services <p><i>Pre-certification may be required.</i></p> | <p>80% of eligible charges; <i>subject to deductible.</i></p> <p>Physical, speech, cardiac and occupational therapies are limited to 40 visits per incident type per plan year.</p> |
| <p><u>Limited Medical Coverage for Dental/ Oral Care</u></p> <ul style="list-style-type: none"> • Surgical Extraction of Impacted Teeth <p><i>Medical benefits are not available for partially erupted teeth.</i></p> | <p>90% of eligible charges for surgeon; <i>subject to deductible.</i></p> |
| <ul style="list-style-type: none"> • Dental/Oral Care <p><i>Not covered; other than accidental injury to natural teeth. (initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily injury to sound natural teeth or structure occurring while a member is covered by this contract and performed within 180 days after the accident.)</i></p> | <p>80% of eligible charges; <i>subject to deductible; subject to balance billing if services are not rendered by a network provider.</i></p> <p><i>Network providers may not be available for all covered services.</i></p> |

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

Other Coverage Rules

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

***Quarterly Out-of-Pocket Maximums
For Use of Generic and Preferred Brand
Medications***

| | |
|-------------------|---------------------|
| Employee | \$450 per quarter |
| Employee + Child | \$900 per quarter |
| Employee + Spouse | \$900 per quarter |
| Family | \$1,350 per quarter |

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

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

| SELECTED PLAN FEATURES AND COVERED SERVICES | PLAN PROVISIONS AND BENEFITS |
|---|---|
| <p><u>Mental Health and Substance Abuse</u></p> <p><i>Pre-certification is required.</i></p> <p>Vendor: BCBSGa (within the State of Georgia) and BCBS National Participating Provider Network (outside the State of Georgia)</p> | <p><u>Inpatient</u></p> <p>90% of eligible charges, subject to deductible. Maximum benefit coverage of 60 days per person per plan year; 90 days per person per lifetime.</p> <p><u>Outpatient</u></p> <p>80% of eligible charges; subject to deductible. Maximum benefit coverage of 20 visits per person per plan year.</p> <p>BCBSGa may approve 30 additional visits per year under the following conditions: (1) in lieu of inpatient treatment; or (2) immediately following hospital confinement for the same condition.</p> <p>Failure to access these BCBS programs or networks will result in the member being subject to balance billing.</p> |
| <p><u>Organ and Tissue Transplants</u></p> <p><i>The Centers of Expertise Programs direct patients to network heart, liver, lung and bone marrow transplant specialists.</i></p> <p>Prior approval is required.</p> | <p>90% of network rate at a COE contracted transplant center; subject to deductible and to separate \$100 hospital deductible.</p> <p>The lifetime benefit limit for expenses related to a donor search, when using a COE contracted transplant Center, is \$10,000.</p> <p>60% of eligible charges at a non-contracted COE transplant center; subject to deductible, to separate \$100 hospital deductible, and to balance billing.</p> <p>There will be no donor search benefit provided if an individual uses a non-contracted COE transplant center.</p> <p>Lifetime benefit limit of \$500,000 (Transplant phase and \$10,000 donor search benefit).</p> |

WHO CAN ENROLL

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

HOW TO ENROLL

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

The indemnity healthcare plan provides four levels of coverage:

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

DEPENDENT COVERAGE

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

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

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

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

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

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

WHEN EMPLOYEE COVERAGE BEGINS

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

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

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

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

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

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

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

WHEN DEPENDENT COVERAGE BEGINS

An eligible dependent will become covered on:

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

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

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

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

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

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

ADDING OR DELETING DEPENDENTS

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

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

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

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

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

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

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

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

Your indemnity healthcare plan will provide coverage for your full-time student dependent until he/she attains age 26. *On a dependent's 26th birthday*, his/her indemnity healthcare coverage will terminate. For information regarding your dependent's ability to continue healthcare coverage, please see page 59 for the section entitled, *Your COBRA Rights*.

USG OPEN ENROLLMENT PERIOD

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

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

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

THE COST OF YOUR HEALTHCARE COVERAGE

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

QUALIFYING EVENTS FOR CHANGES IN HEALTHCARE PLAN COVERAGE

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

December 31.) The only exception permitted under IRS rules is when a covered member has a *qualifying event*.

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

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

Example:

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

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

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

Qualified Medical Child Support Order (QMCSO)

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

PLEASE NOTE:

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

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

CONTINUATION OF HEALTHCARE COVERAGE INTO RETIREMENT

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

USG RETIREE ANNUAL CHANGE PERIOD

The USG retiree annual change period is generally held during the fall of each calendar year. The USG retiree annual change period will coincide with the same 30 calendar-day time frame designated as the USG open enrollment period for active, eligible employees. The institutional

Human Resources/Personnel Office, from which an individual retires, will advise the retiree of the specific dates for his/her annual change period.

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

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

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

QUALIFYING EVENTS FOR CHANGES IN RETIREE HEALTHCARE PLAN COVERAGE

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

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

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

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

A Qualified Medical Child Support Order (QMSCO) is a court-ordered remedy resulting from a divorce, legal separation, annulment, or change in legal custody. A QMSCO requires that an individual provide healthcare coverage for an enrolled dependent(s) that has been approved by the court. The court order and effective date of healthcare plan coverage for a court-designated

enrolled dependent(s) must be presented to the institutional Human Resources/Personnel Office from which an individual retired, within 90 days of the court's decision.

PLEASE NOTE:

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

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

PERMISSIBLE USG RETIREE HEALTHCARE PLAN CHANGES

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

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

THE ANNUAL DEDUCTIBLE

The annual deductible is an amount of money that you will be required to pay each plan year (January 1 – December 31) for covered benefit expenses, before the plan will begin to pay for its portion of covered charges. The maximum annual deductible that a covered member, under the indemnity plan, will pay is \$300 for individual coverage and \$900 for family coverage. The family deductible can be met through any combination of covered medical expenses incurred by three or more covered members within a household. *Member co-payments for prescription drugs will not apply toward the annual deductible for the indemnity healthcare plan. Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).*

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

The indemnity plan provides for a member's protection if his/her out-of-pocket covered expenses reach a certain limit during a plan year. The annual out-of-pocket limit is \$2,000 for individual coverage and \$4,000 for family coverage.

If your individual or family out-of-pocket covered expenses reach these respective limits during the plan year, the plan will pay for 100% of the covered expenses that you and/or your family incur for the remainder of the plan year.

Just as with the family annual deductible, the family maximum annual out-of-pocket limit can be met through any combination of covered medical expenses incurred by three or more covered members within a household. The family out-of-pocket limit can be met without each family member meeting a separate, individual out-of-pocket limit; however, the total out-of-pocket amount must equal \$4,000.

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

- Expenses for medical services that are not covered by the indemnity plan (page 46-48);
- Expenses for medical services in which the member fails to comply with the Medical Utilization Review Program requirements (pages 27-29);
- Expenses for covered medical services that exceed the usual, customary and reasonable (UCR) contracted amounts (page 22);
- Expenses for medical services exceeding other plan limits;
- Expenses for incurred medical and pharmacy services that exceed the maximum lifetime benefit of \$2 million;
- Expenses for medical services that are not paid by the University System of Georgia indemnity plan because of a coordination of benefits (COB) with any other plan(s) that covers you and/or your dependents (page 57);
- Balance billing costs incurred by a member for his/her use of a non-participating physician (page 23-24); and
- Member co-payments for prescription drugs (pages 44-46).

MAXIMUM LIFETIME BENEFIT

The maximum lifetime medical and pharmacy benefits the indemnity healthcare plan will pay is \$2,000,000 per person.

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

annual and/or lifetime maximum amount for TMJ care (*diagnostic testing* and *non-surgical* benefits), organ and tissue transplants, and/or mental health/substance abuse treatment is included in the \$2,000,000 maximum lifetime medical benefit.

- There is a separate lifetime limit of \$1,000 for the *diagnostic testing* and *non-surgical* treatment of *Temporomandibular Joint Disorders (TMJ)* **or** *orofacial pain*. Covered medical benefits include diagnosis, x-ray, splinting, physical therapy, and subsequent follow-up treatments.
- *Organ and Tissue Transplant* services have a maximum lifetime benefit limit of \$500,000. The lifetime benefit limit for expenses related to the donor search for an individual who uses a COE contracted transplant center is \$10,000. This donor search benefit is included in the \$500,000 Organ and Tissue Transplant maximum lifetime benefit. ***Prior approval is required.***
- There are annual and lifetime maximum benefit limits for both inpatient and outpatient *Mental Health and Substance Abuse* treatment services.
 - *Inpatient*: Maximum benefit coverage of 60 days per person per plan year; 90 days per person per lifetime; ***pre-certification is required.***
 - *Outpatient*: Maximum benefit coverage of 20 visits per person per plan year. BCBSGa may approve up to 50 visits per plan year under the following conditions: (1) in lieu of inpatient treatment; or (2) immediately following a hospital confinement for the same condition.

ADMINISTRATIVE AGENTS/BUSINESS ASSOCIATES

The current administrative agents/business associates for the University System of Georgia indemnity healthcare plan include:

(A) Blue Cross Blue Shield of Georgia

- Provides customer service; and
- Provides claims administration services.
- BCBSGa Participating Physician Program – Provides the network of medical providers within the State of Georgia.
- Provides pre-certification for specific outpatient and all inpatient hospital services;
- Provides case management services;
- Provides access and education regarding 360° Health Programs.
- Provides access for organ and tissue transplant network Centers of Expertise;
- Provides access to 24/7 Nurseline member services, and;
- Provides mental health medical review.

(B) Blue Cross Blue Shield Association

- BCBS National Participating Provider Network – Provides the network of medical providers, hospitals, and facilities outside of the State of Georgia.

(C) Medco

- Provides pharmacy benefit program services.

HOW YOUR INDEMNITY HEALTHCARE BENEFITS PLAN WORKS

The indemnity healthcare plan covers only eligible charges that are:

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

The following professionals are considered to be covered providers under the plan, when acting within the scope of their licenses *and* when rendering services as defined by the plan. These professionals include optometrists, clinical psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors.

- **Within UCR:** Usual, customary and reasonable (UCR) as set by BCBSGa/BCBS. Each term has a specific meaning:
 - **Usual:** The fee which a physician most frequently charges for the procedure performed;
 - **Customary:** A fee based upon a competitive profile of the usual fees received as reimbursement by similar physicians in a given geographic areas for the procedure performed; and
 - **Reasonable:** A fee which differs from usual or customary fees because of unusual circumstances or complications occurs in which require additional time, skill and experience.

The indemnity healthcare plan will pay up to the usual fee, not to exceed the customary fee, unless special circumstances or complications occur. If special circumstances or complications occur, the plan may consider the reasonable fee.

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

THE PARTICIPATING PHYSICIAN PROGRAM

BCBSGa Participating Physician Program

(Within the State of Georgia)

The Participating Physician Program helps reduce your out-of-pocket indemnity plan medical expenses for covered physician services. This program, established by Blue Cross Blue Shield of Georgia (BCBSGa), is a voluntary, statewide arrangement between BCBSGa and physicians that are eligible to practice in Georgia.

Each participating physician must agree to accept the indemnity plan's established UCR fee limit as the maximum payment amount for his/her professional services. This means that once you have met your deductible, you will pay only for your appropriate portion of covered medical charges.

THE NATIONAL PARTICIPATING PROVIDER NETWORK

BCBS National Participating Provider Network

(Outside of the State of Georgia)

The Blue Cross Blue Shield (BCBS) National Participating Provider Network is a network that is similar in scope to the existing BCBSGA Participating Physician Program. With this network, the providers have contracted with their local Blue Cross Blue Shield plan in the state where the provider practices.

Within the BCBS National Participating Provider Network, physicians and facilities have agreed to accept the "allowable charge" as the maximum payment for their services. "Allowable charge" will be based upon the contracted rate that a national participating provider has agreed to accept from the local BCBS plan in the state where the services are rendered.

Healthcare plan participants, who access either the BCBS National Participating Provider Network or the BCBSGa Participating Physician Program, **will not** be subject to balance billing. In addition, a participating physician will prepare and file all of your medical claims for you. ***Plan benefits are paid directly to participating physicians.*** Failure to access these BCBS programs or networks **will result** in the member being subject to balance billing.

Physicians who are eligible to participate in the BCBSGA/BCBS programs are those who meet the definition of *physician* as identified earlier in this booklet.

It is always your choice to select and use either a participating physician or a non-participating physician. Please be informed that many non-participating physicians will not file your medical claims for you.

Please, also, be informed that a non-participating physician has not signed an agreement with BCBSGA/BCBS to accept the indemnity plan's UCR/eligible charge fee limit as the maximum payment amount for his/her professional services.

This means that you may be subject to balance billing. *Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).*

To determine if your physician is a BCBSGa/BCBS participating provider, please ask him or her. When visiting a new physician, or when being referred to a specialist, it is wise to check in advance to see if he/she is a BCBSGa/BCBS participating physician. Information regarding the physicians who participate in BCBSGa Georgia network may be determined by contacting the BCBSGa Customer Service at 1-800-424-8950 or TDD 404-842-8073. To determine if your physician or facility located outside of Georgia is in the BCBS National Provider Network, please contact BCBS Association Customer Service at 1-800-810-BLUE (2583) or www.bcbs.com.

These telephone numbers are listed on your indemnity plan identification card. You may also obtain this information by accessing the University System of Georgia website at www.usg.edu/employment/benefits/health.

THE INTERNATIONAL PARTICIPATING PROVIDER NETWORK

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

PLEASE NOTE:

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

WELLNESS CARE/PREVENTIVE HEALTHCARE

The indemnity plan will provide wellness benefits of up to \$750 per person per plan year. The wellness benefit is paid at 100% of eligible charges and is not subject to a member deductible. Charges for wellness services in excess of the annual \$750 maximum level benefit are not eligible for reimbursement under any other category of plan coverage. Wellness care/preventive healthcare services include:

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

Under this benefit, well-baby care includes routine physical exams, immunizations, x-rays, laboratory tests, and other tests billed by the attending physician for services rendered in his/her office.

Treatment of suspected/identified illnesses or injuries *and* allergy injections *are not* covered by the wellness benefit.

TREATMENT OF DISEASES OF THE EYE

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

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

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

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

BlueChoice Vision Program through Special Offers

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

SECOND MEDICAL OPINION FOR ELECTIVE SURGERY

A member is permitted to obtain a second medical opinion for an elective surgery. The indemnity plan will cover 100% of eligible charges for a second medical opinion. The charges for the second physician's consultation services are not subject to a deductible. Please be reminded that an elective surgery must be deemed to be medically necessary to receive plan benefits.

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

MEDICAL UTILIZATION MANAGEMENT REVIEW PROGRAM

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

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

Specific Outpatient Medical Procedures - To access benefits coverage for specific outpatient medical procedures/diagnostic testing, BCBSGa must determine if: (1) the procedure is medically necessary; and/or (2) if an appropriate and alternative treatment is available.

For the specific listing of outpatient procedures that require BCBSGa pre-certification, please review the section entitled, "*Pre-certification for Certain Outpatient Procedures/Diagnostic Tests*", located on pages 31-32.

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

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

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

- ***Continued Inpatient Hospital/Medical Facility Confinement Review*** - During an approved hospital/medical facility confinement, BCBSGa will monitor a patient's progress by consulting with his/her attending physician.

BCBSGa will consult with the attending physician to ensure that the recommended treatment plan is consistent with medical benefits covered by the healthcare plan design. BCBSGa will, also, review and render decisions for requests to extend periods of inpatient hospital/medical facility confinement.

- ***Available Alternative Medical Services/Care Review Process*** - BCBSGa will identify patients for whom early discharge from a hospital/medical facility to a home healthcare environment is appropriate. BCBSGa will identify a provider, from a nationwide network of contracted home healthcare agencies, to provide necessary services/care for the patient. Home healthcare agency treatment plans for the patient will be monitored by BCBSGa.

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

- Hospital confinements, including emergency room admissions and surgery;
- Inpatient psychiatric or substance abuse treatment, including transitions to lower levels of care;
- Certain outpatient procedures and diagnostic testing;
- Organ and tissue transplants;
- Confinement in an extended care facility (following or in lieu of an inpatient hospital stay);
- Home healthcare;
- Hospice care;
- Home hyperalimentation; and
- Private duty nursing.

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

Should you elect to receive home healthcare, hospice care, or private duty nursing; or should you be confined in an extended care facility ***without the prior approval, no plan benefits will be paid.***

PLEASE NOTE:

Blue Cross Blue Shield of Georgia (BCBSGa) Participating Physician Program

When a member uses a BCBSGa participating physician, the medical provider is responsible for obtaining the required pre-certification for a hospital confinement or for a prescribed outpatient procedure/diagnostic test.

Blue Cross Blue Shield (BCBS) National Participating Provider/Non-Participating Physician

When a member uses a BCBS National Participating Provider, or a non-participating physician, it is **the member's responsibility** to obtain the necessary pre-certification for a hospital confinement or for a prescribed outpatient procedure/diagnostic test.

The member must contact BCBSGa **at least 48 hours** prior to his/her scheduled medical procedure, unless the procedure is an emergency.

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

Remember: Precertification is not a guarantee of payment.

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

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

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

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

MATERNITY AND NEWBORN INFANT NURSERY CARE BENEFITS

After meeting your deductible, the plan will pay 90% of eligible charges for all covered charges associated with prenatal, delivery, and postnatal maternity care when billed global (*services that are billed separately will be reimbursed at 80%*) The plan will pay for 90% of the eligible covered hospital charges.

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

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

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

Congress has passed the Newborns' and Mothers' Health Protection Act of 1996. This federal statute created a minimum length of inpatient hospital care that must be provided for mothers and newborns having healthcare coverage under a group or individual healthcare plan. The respective University System of Georgia healthcare plans comply with this federal mandate. The minimum length of inpatient care will vary depending upon the medical condition of the mother. The minimum length of stay following a normal vaginal delivery is 48 hours and the minimum of length of stay following a cesarean section is 96 hours. If the attending physician, in consultation with the mother, decides to discharge the mother and/or newborn prior to the mandated minimum stay, the hospital confinement requirements will not apply.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

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

PRE-CERTIFICATION FOR CERTAIN OUTPATIENT PROCEDURES/DIAGNOSTIC TESTS (PLAN YEAR 2009)

Certain outpatient procedures and diagnostic tests will require pre-certification. When your physician recommends an outpatient procedure, please ask that your doctor provide you with the CPT code for that procedure.

You may then contact the Medical Utilization Management Review program (1-800-233-5765/TDD 1-800-368-4424) or the BCBSGa Customer Service unit (1-800-424-8950/TDD 404-842-8073) to determine whether pre-certification is required.

If a procedure requires pre-certification, you must call the Medical Utilization Management Review program *at least 48 hours prior to the scheduled procedure*, unless the procedure is an emergency. Outpatient pre-certification review is not required for covered retirees/covered spouses of retirees who have Medicare Part B. The following medical CPT procedure categories require pre-certification:

Description CPT Code

MRIs:

Cervical 72141, 72142, 72156

Thoracic 72146, 72147, 72157

Lumbar 72148, 72149, 72158

Abdomen 74181 – 74183

Pelvis 72195 – 72197

Extremity: Upper (Nonjoint) 73218 - 73220

Extremity: Upper (Joint) 73221 - 73223

Extremity: Lower (Nonjoint) 73718 - 73720

Extremity: Lower (Joint) 73721 - 73723

Chest 71550 – 71552

Orbit, Face, Neck 70540 – 70543

Miscellaneous (3D or Holographic Reconstruction of a CT, MRI or Other Tomographic Modality)

76376 or 76377

Pet Scans

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

CAT Scans:

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

CT Angiography (CTA)

Thorax 71260 & 71270
Chest (noncoronary) 71275
Abdomen 74175
Abdominal aorta 75635
Pelvis 72191
Upper Extremity 73206
Lower Extremity 73706
Heart 0144T, 0146T, 0147T, 0148T, 0149T, & S8092
Colonoscopy 45378 - 45385
Insulin Pump E0784

MRAs:

Chest 71555, C8909-C8911
Upper Extremity 73225,
Lower Extremity 73725, C8912-C8914
Abdomen 74185, C8900-C8902
Pelvis 72198, C8918-C8920
Spinal Canal 72159

PLEASE NOTE:

Blue Cross Blue Shield of Georgia (BCBSa) Participating Physician Program

When a member uses a BCBSGa participating physician, the medical provider is responsible for obtaining the required pre-certification for this outpatient procedures/diagnostic tests.

**Blue Cross Blue Shield (BCBS) National Participating Provider
/Non Participating Physician**

When a member uses a BCBS National Participating Provider or a non-participating physician, it is **the member's responsibility** to obtain the necessary pre-certification for these prescribed outpatient procedure/diagnostic tests.

The member must contact BCBSGa **at least 48 hours** prior to his/her scheduled medical procedure, unless the procedure is an emergency.

If a member fails to comply with Medical Utilization Management Review requirements, you **will be responsible for all charges. Any days exceeding the authorized length of stay will be denied and you will be responsible for all related charges.**

Remember: Precertification is not a guarantee of payment.

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

The final decision regarding the appropriate level of medical treatment for you and your family continues to be the joint responsibility of you and your physician. The Medical Utilization Management Review program is designed to evaluate medical alternatives.

It is not designed, nor intended, to practice medicine. The review process does not replace the medical advice of your physician; the review process ensures that you are aware of all medical options before you receive care.

MEDICAL CASE MANAGEMENT

The Medical Case Management program, administered by BCBSGa, is designed to assist with the complexities and costs of a catastrophic illness or injury. This program employs early intervention strategies to identify such cases. The program provides continuous medical case management from hospitalization through discharge and recovery.

BCBSGa physicians, case managers and rehabilitation specialists work with a patient's attending physician to facilitate the most appropriate medical treatment and setting. The Medical Case Management program is automatically activated by BCBSGa when a member experiences a catastrophic illness or injury.

EXTENDED CARE FACILITY

After meeting your deductible, the plan will pay for 90% of eligible charges for extended care facility services. ***BCBSGa must review and pre-certify all extended care facility services.***

An extended care facility is a skilled nursing facility qualified to receive Medicare payments, or one that operates in accordance with local laws under the full-time supervision of a licensed nurse or doctor.

It must provide room and board and 24-hour-a-day skilled nursing care of sick and injured persons, at the patient's expense, during the convalescent stage of an injury or illness.

Extended care facilities do not include institutions operated primarily for the care of the aged; treatment of mental disease; drug addiction; alcoholism; or educational or custodial care.

HOME HEALTHCARE SERVICES

After meeting your deductible, the plan will pay for 90% of eligible charges for home healthcare services. ***BCBSGa must review and pre-certify all home healthcare services.***

Home healthcare services that are covered include:

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

- Nutritional counseling that is provided or supervised by a registered nurse (RN).

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

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

DURABLE MEDICAL EQUIPMENT (DME)

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

DME must meet the following criteria:

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

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

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

Some of the DME items that **are not** covered by the indemnity healthcare plan include, but are not limited to:

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

HOSPICE CARE SERVICES

A hospice program provides for the care and counseling of terminally ill patients and their families. After meeting your deductible, the plan will pay for 90% of eligible charges for hospice care services. ***BCBSGa must review and pre-certify all hospice care services.***

Hospice care services that are covered include:

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

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

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

360° Health Programs

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

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

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

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

Program Descriptions

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

Asthma (adult and pediatric)

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

Diabetes (adult and pediatric)

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

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

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

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

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

Chronic Obstructive Pulmonary Disease (COPD)

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

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

MyHealth Coach

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

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

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

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

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

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

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

24/7 NurseLine PROGRAM

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

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

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

Hospital Emergency Room Care - 24/7 NurseLine nurses have the authority to issue hospital emergency room referrals. Emergency room referrals by **24/7 NurseLine** will result in a higher level of benefit coverage for the member. If an emergency room referral is obtained from **24/7 NurseLine**, the level of benefit coverage for surgical services will be 90% and the level of benefit coverage for non-surgical services will be 80%.

If an emergency room referral *is not* obtained from **24/7 NurseLine**, the level of benefit coverage for surgical services will be 80% and the level of benefit coverage for non-surgical services will be 70%. If a member is admitted to the hospital following emergency room care, he/she will receive the higher level of benefit coverage.

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

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

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

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

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

ORGAN AND TISSUE TRANSPLANT PROGRAM

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

The organ and tissue transplant program uses literature-based protocols. These protocols guide COE physicians and members of the COE transplant panel in the completion of medical review determinations. Each member who participates in the *Organ and Tissue Transplant* program will have a Transplant Coordinator.

The Transplant Coordinator will introduce the patient to the program; explain the program procedures; and assist the patient with the coordination of any needed home care services. The program provides for patient access to a specialty-matched physician reconsideration process.

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

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

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

Should you desire additional information, or should you wish to participate in the Centers for Expertise *Organ and Tissue Transplant* program, please call 1-800-828-6518/TDD 1-800-368-4424.

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

COVERED EXPENSES

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

Inpatient Hospital and Physician Services – 90%

After meeting your deductible, the plan will pay for 90% of the eligible charges for covered inpatient hospital services rendered within the State of Georgia and for 90% of eligible charges for inpatient hospital services rendered outside the State of Georgia. Covered inpatient hospital services include:

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

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

Inpatient Hospital and Physician Services – 80%

After meeting your deductible, the plan will pay for 80% of eligible charges for:

- Anesthesiologist, pathologist, or radiologist services/consultations; and
- Pre-admission testing, if performed within a seven-day period prior to a scheduled hospital confinement.

Outpatient Hospital/Facility Services – 90%

After meeting your deductible, the plan will pay for 90% of eligible covered charges for:

- Emergency room ***surgical*** services, if a referral to the emergency room is obtained from 24/7 Nurseline;
- Physician charges for ***surgical*** procedures;
- ***Surgical*** charges associated with the removal of impacted teeth;
- Cochlear implants;
- Outpatient surgical facility selected by a treating physician which is a Plan approved facility;
- Treatment provided in an extended care facility;
- Home hyperalimentation;
- Treatment provided through a home nursing care program; and
- Services provided through a hospice care program.

Outpatient Hospital/Facility Services – 80%

After meeting your deductible, the plan will pay for 80% of eligible charges for:

- Physician charges for services/consultations rendered by an anesthesiologist, pathologist, or radiologist;
- Emergency room ***non-surgical*** services, if a referral to the emergency room is obtained from 24/7 Nurseline;
- Laboratory charges, including x-rays and diagnostic testing/examinations;
- Ambulance service for medically necessary emergency transportation, to the nearest facility providing the required treatment; and

- Outpatient short-term rehabilitation services. Your benefit provides for: ***physical, speech, cardiac and occupational therapies*** that are limited to a ***maximum of 40 visits*** per incident type per plan year. To receive a benefit for ***speech therapy***, there must be a medically diagnosed condition of inability to speak/loss of speech due to illness, surgery, or birth defect. Services must be provided by a qualified speech therapist.

Physician Services Provided in an Office Setting – 100%

The plan will pay for 100% of eligible charges for:

- Wellness care/preventive healthcare (limited to \$750 per person per plan year); and
- Second surgical opinions for elective surgery.

Physician Services Provided in an Office Setting – 90%

After meeting your deductible, the plan will pay for 90% of eligible charges for:

- Outpatient surgery provided in a physician office setting;
- Surgical removal of impacted teeth, other than partially erupted teeth; and
- Maternity care (prenatal and postnatal). 90% of eligible charges when billed global; subject to deductible. (services that are billed separately will be reimbursed at 80%)

Physician Services Provided in an Office Setting – 80%

After meeting your deductible, the plan will pay for 80% of eligible charges for:

- A physician's office visit for non-surgical services;
- Laboratory charges, including x-rays and diagnostic testing/examinations (exclusive of wellness care/preventive healthcare);
- Allergy testing, shots and serum;
- Diagnostic testing and ***non-surgical*** treatment of temporomandibular joint disorders (TMJ); and
- Expenses incurred for rental or purchase of durable medical equipment (DME) or supplies, if medically necessary.

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

After meeting your deductible, the plan will pay for 90% of covered charges for *inpatient* mental health and substance abuse treatment services. The plan provides for maximum benefit coverage of 60 days per person per plan year; 90 days per person per lifetime. Care and treatment must be provided in an approved hospital. ***Pre-certification for inpatient mental health and substance abuse treatment services is required***

After meeting your deductible, the plan will pay for 80% of covered charges for *outpatient* mental health and substance abuse treatment services. The plan provides for maximum benefit coverage of 20 visits per person per plan year. BCBSGa may approve up to 50 visits per person per plan year under the following conditions: (1) in lieu of inpatient treatment; or (2) immediately following a hospital confinement for the same condition.

Physician services provided for the treatment of Attention Deficit Disorder (ADD) will apply towards the outpatient mental health visit limitation of 20 visits per plan year.

Mental health and substance abuse treatment services must be medically necessary and must be provided by a qualified professional. A qualified professional is a licensed psychiatrist; a licensed clinical psychologist; a licensed clinical social worker; a licensed professional counselor; and/or a licensed marriage and family therapist. The plan design will provide benefits coverage for treatment services provided by a qualified professional that relate to psychiatric or substance abuse diagnoses.

A BCBSGa approved hospital means a hospital, an outpatient treatment facility, or a residential treatment facility. A convalescent nursing home is not deemed to be a BCBSGa approved hospital under this specific plan benefit. A residential treatment facility is an institution that is established and operated in compliance with applicable state statutes. A residential treatment facility provides for the treatment of psychiatric conditions, alcoholism, chemical dependency, or drug addiction. The facility must provide room and board; evaluation and diagnosis; counseling; and referral/orientation to specialized community resources. A residential treatment facility must maintain a written, specific regimen requiring full-time residence and participation by the patient.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICE PROVIDERS

BCBSGa Program (Within the State of Georgia)

One of the features that are included in the indemnity healthcare plan to help reduce your out-of-pocket costs is the BCBSGA Program. Similar to the BCBSGa Participating Physician Program, this program provides a network of ***mental health facilities*** that have agreed to accept the indemnity plan's established UCR fee limit as the maximum payment for the professional

treatment services that are provided *within the State of Georgia*. The BCBSGa Program applies to both inpatient and outpatient mental health facility treatment services.

BCBS National Participating Provider Network (Outside the State of Georgia)

The BCBS National Participating Provider Network is a network that is similar in scope to the existing BCBSGa Program. With this network, the providers have contracted with their local Blue Cross Blue Shield plan in the state where the provider practices.

Within the BCBS National Participating Provider Network, physicians and facilities have agreed to accept the “allowable charge” as the maximum payment for their services. “Allowable charge” will be based upon the contracted rate that a national participating provider has agreed to accept from the local BCBS plan in the state where the services are rendered. The BCBS National Participating Provider Network applies to both inpatient and outpatient mental health facility treatment services. Healthcare plan participants, who access either the BCBSGa Program, or the BCBS National Participating Provider Network, **will not** be subject to balance billing.

It is always your choice to select or use a mental health facility *that is* or *that is not* a part of the BCBSGa Program or the BCBS National Participating Provider Network. Please be informed that if you select a mental health facility *that is not* a participant in these BCBS networks or programs, you may be subject to balance billing for mental health and substance abuse treatment services that are provided. ***Member costs incurred for balance billing will not apply toward the annual deductible or toward the annual maximum out-of-pocket limits (stop loss).***

To determine if a mental health facility is a member of the BCBSGa Program or of the BCBS National Participating Provider Network, please ask the facility administrator. It is wise to check with the mental health facility in advance of receiving treatment services.

Information regarding the physicians/facilities that participate in BCBSGa Prudent Buyer network (*within the State of Georgia*) may be determined by contacting the BCBSGa Customer Service at 1-800-424-8950 or TDD 404-842-8073. To determine if your *out of state* physician or facility is in the BCBS National Provider Network, please contact BCBS Association Customer Service at 1-800-810-BLUE (2583). These telephone numbers are listed on your indemnity plan identification card. You may also obtain this information by accessing the University System of Georgia website at www.usg.edu/employment/benefits/health.

PLEASE NOTE:

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

PHARMACY BENEFIT MANAGEMENT (PBM) PROGRAM

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

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

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

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

Days Supply

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

Maintenance Medications

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

Other Coverage Rules

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

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

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

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

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

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

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

Coverage Management Program

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

Coverage Reviews/Prior Authorizations

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

Other Coverage Rules

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

EXPENSES THE INDEMNITY HEALTHCARE PLAN DOES NOT COVER (Exclusions)

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

- Those that exceed the usual, customary and reasonable (UCR) limit for covered charges;
- Those that are not medically necessary;
- Those that could have been provided in a more cost-effective manner, without affecting the patient's good health. (Example: Incurring hospital charges for a Friday or Saturday inpatient hospital admission, unless the weekend admission was deemed medically necessary);
- Those that are provided by an immediate family member or household resident;
- Those that are not recommended/approved by an attending physician;
- Those that were received prior to being eligible for plan participation and coverage;
- Those that may be covered by state or federal programs, such as items covered by Workers' Compensation or Medicare;
- Those charges incurred by a member from his/her physician for failure to keep a scheduled appointment;
- Those that are for the medical/surgical management of weight loss *or* for gastric-restrictive procedures associated with the correction of obesity (i.e. Gastric Bypass);
- Those that are for fitness/exercise programs;
- Those that are to correct a speech deficiency or to improve a habitual speech disorder;
- Those that are associated with cosmetic surgery, except for charges related to accidental injury, corrective surgery for congenital anomalies, and/or reconstructive surgeries following a mastectomy;
- Those for hair transplants, hair pieces or wigs;
- Those for hearing aids;
- Those for foot orthotics and/or foot inserts;

- Those that are incurred, directly or indirectly, from participating in an insurrection, a war, or the service in the armed forces of any country;
- Those that are custodial in nature;
- Those that are investigational/experimental in nature;
- Those for hypnotherapy;
- Those for infertility drugs or artificial insemination agents;
- Those associated with any type of infertility treatment/procedures or testing; including, but not limited to, artificial insemination, invitro-fertilization, embryo transfer processes, and/or reversal sterilization;
- Those for the treatment of sexual dysfunction or inadequacies, including the treatment for impotency (except male organic erectile dysfunction);
- Those for a sex transformation;
- Those for acupuncture therapy;
- Those for child, career, social adjustment, financial, pastoral or marriage counseling;
- Those for therapy for conditions related to hyper-kinetic syndromes, learning disabilities, behavioral problems, mental retardation or speech disorders;
- Those that are not provided by a legally licensed physician. The medical services and/or treatment provided must be within the scope of the physician's license;
- Those that are provided by a chiropractor;
- Those for nutritional supplements; unless sole source of nutrition (prior approval required);
- Those for smoking cessation programs;
- Those for dental work, dental X-rays, implants or dentures, periodontal and osseous surgery unless the procedure results from accidental injury to natural teeth sustained while covered under the plan; and
- Those for radial keratotomy; and/or for the surgical correction of nearsightedness, astigmatism, or any other correction of vision due to a refractive problem.

WHEN YOUR INDEMNITY HEALTHCARE PLAN COVERAGE ENDS

Your coverage, under the indemnity healthcare plan, will end on the last day of the month in which:

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

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

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

WHEN INDEMNITY HEALTHCARE PLAN COVERAGE FOR YOUR ELIGIBLE AND COVERED DEPENDENT(S) ENDS

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

- Your dependent(s) ceases to be eligible;
- You are no longer eligible to participate in the plan;
- Your dependent(s) becomes eligible for coverage under the plan, as a University System of Georgia employee;
- You elect to withdraw from the plan during an open enrollment period;

- Your employment is terminated;
- You elect to reduce your level of benefit coverage: (1) from “family” coverage to “employee + child” coverage, to “employee + spouse” coverage, or to “single” coverage; or (2) from “employee + child” coverage or “employee + spouse” coverage to “single” coverage;
- You fail to make any required employee contribution; or
- The plan is terminated.

If your indemnity healthcare plan coverage ends, you and/or your dependents may be eligible for an extension of coverage under the special provisions of the plan. Please see the section entitled, “*Coverage After Retirement*”, located on page 50, or the section entitled, “*Extended Coverage for Your Dependents After Your Death*”, located on page 51 of this booklet.

COVERAGE FOR ACTIVE EMPLOYEES AGE 65 OR OVER

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

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

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

COVERAGE AFTER RETIREMENT

When a member retires from active service with the University System of Georgia, participation in the indemnity healthcare plan may be continued into retirement if the member complies with the requirements as prescribed by the Board of Regents *Policy Manual*. A member who enters retirement may continue with the same level (single, employee + child, employee + spouse, or family) of healthcare coverage that he/she had immediately prior to retirement. On page 17 of this booklet, information is provided regarding the *USG Retiree Annual Change Period*.

Continued participation in the healthcare plan is voluntary. You will continue to pay your employee portion of the monthly premium. The institution from which you retired will continue to pay the employer’s share of your monthly premium. The costs of healthcare plan premiums for employees, retirees and dependents of the University System of Georgia changes periodically. Your campus Human Resources/Personnel Office will notify you of any changes in plan costs and in employer/employee contribution rates.

If you carry “*employee + child*” healthcare coverage or “*employee + spouse*” healthcare coverage or “*family*” healthcare coverage into retirement, ***and*** you predecease your spouse, your covered dependents will be permitted to continue their healthcare coverage. Healthcare coverage for the spouse will continue until his/her death or remarriage. Coverage for dependent children would continue until they ceased to be eligible.

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

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

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

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

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

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

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

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

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

A dependent, of an active employee who dies with less than ten years of service, may remain as a participant in the indemnity healthcare plan for no more than 12 consecutive months after the death of the employee. The University System of Georgia will pay the employer portion of the healthcare plan premiums for this 12 month period. After this 12-month period, a dependent may elect to continue his/her healthcare coverage through COBRA. However, the COBRA coverage period to which the dependent may be entitled due to the death of the employee will be reduced by this 12-month period of coverage. For information regarding *Your COBRA Rights*, please see page 59 of this booklet.

FILING PAPER CLAIMS/USE OF A PHYSICIAN WHO IS NOT A MEMBER OF THE INDEMNITY HEALTHCARE PROGRAMS OR NETWORK

USE OF NON-PARTICIPATING PROVIDER WITHIN THE STATE OF GEORGIA

If you receive medical care from a physician who is not a member of the BCBSGA Participating Physician Program *within the State of Georgia*, you will have *one year* from the date that such service was rendered to file a paper claim and receive reimbursement for covered charges.

Claims for such medical services provided within the State of Georgia should be submitted to:

Blue Cross Blue Shield of Georgia

Post Office Box 7728

Columbus, GA 31908-7728

Telephone: 1-800-424-8950/TDD 404-842-8073

Claims forms for medical services rendered *within the State of Georgia* are available and may be obtained from your campus Human Resources/Personnel Office, from the BCBSGA Customer Service department, or via electronic format from the University System of Georgia website, www.usg.edu/employment/benefits/health.

**USE OF NON-PARTICIPATING PROVIDER
OUTSIDE OF THE STATE OF GEORGIA**

If you receive medical care from a medical provider *outside of Georgia*, who is not a member of the BCBS National Provider Network, you will have to contact BCBSGA Customer Service for assistance. *Claims for medical services provided outside of the State of Georgia must be filed and submitted to the local Blue Cross Blue Shield plan in the state where the services are rendered.* To obtain the name, mailing address and claim form for the local Blue Cross Blue Shield plan, please contact BCBSGA Customer Service at 1-800-424-8950/TDD 404-842-8073 for assistance.

You will have *one year* from the date that such service was rendered to file a paper claim and receive reimbursement for covered charges.

Failure to submit an out-of-state medical claim(s) to a local Blue Cross Blue Shield plan may result in the delayed processing of your benefits. If incorrect benefits are applied to your claim, reimbursement for incurred medical expenses will be further delayed.

GENERAL INFORMATION REQUIRED TO FILE A CLAIM

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

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

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

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

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

PLEASE NOTE:

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

FILING PAPER CLAIMS/FOREIGN CLAIMS WHILE TRAVELING ABROAD

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

BlueCard Worldwide® Service Center
P O Box 72017
Richmond, VA 23255-2017 USA

- For inpatient care at a BlueCard Worldwide® hospital that was arranged through the BlueCard Worldwide Service Center, 1.800.810.BLUE (2583), you only pay the provider the usual out-of-pocket expenses (non-covered services, deductible, co-payment and co-insurance). The provider files the claim for you.
- For all outpatient and professional medical care, you pay the provider and submit a claim. You may also have to pay the hospital (and submit a claim) for inpatient care obtained from a non-BlueCard Worldwide® hospital or when inpatient care was not arranged through the BlueCard Worldwide Service Center.
- All foreign pharmacy claims must be submitted directly to BCBSGa.

- To submit a claim, you complete an International Claim Form and send it to the BlueCard Worldwide Service Center. The claim form must be completed fully otherwise it will be returned to you and payment will be delayed.
- For questions, you may contact your local BCBSGA Customer Service Unit or the BlueCard Worldwide Service Center Outside the U.S. (call collect): 1.804.673.1177

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

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

PLEASE NOTE:

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

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

DENIAL OF A MEDICAL CLAIM BY BCBSGA

If a member has a medical claim that is denied by BCBSGA, he/she will receive written notification from BCBSGA. The denial notice will include:

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

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

APPEALING A DENIED CLAIM

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

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

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

When discussing a claim, please provide the following information:

- Contract holder name and identification number;
 - Patient name and address;
 - Provider name and address (hospital and/or physician);
 - Date/dates of service; and
 - Type of service received.
2. You have the right to submit a written inquiry regarding your denied medical claim. Written inquiries should be directed to:

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

3. You should receive a written response from BCBSGA regarding your initial written inquiry *within 30 calendar days*.
4. Following the review process by BCBSGA, a member may submit a final appeal to the plan administrator. The plan administrator will not accept any member appeal until the entire BCBSGA process has been completed. The member will be required to provide the plan administrator with all supporting documentation presented at the respective levels of the BCBSGA appeal process. The plan administrator will render a final decision.

APPEALING A DENIED Precertification

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

ASSIGNMENT OF BENEFITS

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

- Physicians participating in the BCBSGA Participating Physician Program and physicians, hospitals and facilities participating in the BCBS National Participating Provider Network;

- Mental health hospitals participating in the BCBSGA Program and the physicians, hospitals and facilities participating in the BCBS National Participating Provider Network;
- State of Georgia contracted hospitals; and
- Centers of Expertise participating in the national *Organ and Tissue Transplant* program.

SUBROGATION AND RIGHT OF REIMBURSEMENT

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

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

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

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

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

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

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

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

ADMINISTRATIVE INFORMATION

COORDINATION OF BENEFITS (COB)

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

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

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

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

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

1. A plan without a Coordination of Benefits (COB) provision is primary over a plan with COB provision.

2. A group-insurance medical plan that covers an individual as an active or retired employee is primary over a group-insurance medical plan that covers an individual as a dependent.

An exception to this policy is:

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

3. For *children*, the healthcare plan of the parent whose birthday occurs earlier in the calendar year is deemed to be primary. If both parents' birthdays occur on the same day, the healthcare plan that has insured the parent for the longest period of time is primary. If one of the plans does not have the parent birthday rule, the father's healthcare plan is primary.

4. For children of separated or divorced parents:

(A) When a *court decree has determined that one parent has financial responsibility* for medical, dental or other healthcare expenses of a child, the healthcare plan of the parent with court-decreed financial responsibility is primary to any other plan covering the child (regardless of which parent has custody).

(B) When a *court decree states that the parents will share joint custody*, without specifying which parent has financial responsibilities for medical or dental care expenses of a child, the plan providing primary coverage for the child, will follow the sequence of benefit determination rules presented below:

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

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

1. For healthcare plans that cover a *child of separated or divorced parents who have not remarried*, the healthcare plan of the parent with custody is deemed to be primary.

2. For healthcare plans that cover a *child of remarried parent(s)*:

- The healthcare plan of the remarried parent, with custody, is deemed to be primary;
- The healthcare plan of the step-parent is deemed to be secondary; and

- The healthcare plan of the biological parent, without custody, is deemed to have the third level of healthcare payment responsibility.
- 5. The healthcare plan that covers an insured individual as an active employee is primary over a healthcare plan that covers a retiree or laid-off employee. The same process is true for an active employee covered by his/her employer's group-insurance medical plan who is also covered as a dependent under a retiree's/laid-off employee's group-insurance medical plan. An active employee's healthcare plan will have primary coverage responsibilities.

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

- If you are covered under the indemnity healthcare plan as an active employee or as the spouse of an active employee, the USG indemnity plan will be primary. Your BCBSGA Participating Physician Program and your BCBS National Participating Provider Network will file medical claims with the USG indemnity plan initially and then, with Medicare.

In many cases, your healthcare provider will file your medical claims with the USG indemnity healthcare plan and Medicare simultaneously.

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

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

YOUR COBRA RIGHTS

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

What is COBRA Coverage? COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Qualifying events are listed below. After a qualifying event occurs, and any required notice is properly given, COBRA coverage must be offered to each person losing coverage who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Each qualified

beneficiary has the right to continue the level of coverage in effect on the day before the qualifying event (or a lesser level of coverage). Under the Plan, qualified beneficiaries who elect COBRA must pay for the COBRA coverage.

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

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

Disability Extension of COBRA Coverage. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify your Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered employee's termination of

employment or reduction in hours and must last at least until the end of the COBRA coverage period that would be available without the disability extension. (Generally 18 months). The disability extension is available only if you notify your Employer in writing of the Social Security Administration's determination of disability within 60 days after the later of:

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

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

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

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

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

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

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

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

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

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

PLEASE NOTE:

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

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

- A COBRA-covered disabled family member, who recovers from his/her disability; after the initial 18-month eligibility period and prior to the conclusion of the 29-month COBRA eligibility period;

- The member fails to remit his/her required COBRA healthcare premium within the institutionally approved schedule for payment;
- The University System of Georgia healthcare plan is terminated;
- After election, a qualified beneficiary becomes covered under another group health plan other than a group health plan which may limit a qualified beneficiary's coverage because it involves a pre-existing condition;
- After election, a qualified beneficiary becomes entitled to receive benefits under Medicare; or
- Termination for cause (e. g., submission of a fraudulent claim).

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

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

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

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

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

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

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

Permitted Uses and Disclosures of PHI

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fundraising Activities. Unless you object, the Board may disclose your PHI to contact you for fundraising efforts to support the Board, its related foundations, and/or its cooperative organizations.

Such disclosure would be limited to personal contact information, such as your name, address and telephone number. The money raised in connection with these fundraising activities would be used to expand and support the provision of healthcare and related services to the community.

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

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

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

Regulatory Requirements. The Board is required, by law, to maintain the privacy of your PHI, to provide individuals with notice of the Board's legal duties and PHI privacy practices, and to abide by the terms described in this Notice. The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise its Notice and post a new Notice in conspicuous locations. You have the following rights regarding your PHI.

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

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

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

fees. If you request copies of your PHI, or agree to a summary of your PHI, the Board may impose a reasonable fee to cover copying, postage, and related costs.

If the Board denies access to your PHI, it will explain the basis for the denial. The Board will explain your opportunity to have your request and the denial reviewed by a licensed healthcare professional (who was not involved in the initial denial decision).

This healthcare professional will be designated as a reviewing official. If the Board does not maintain the PHI that you request, but it knows where your requested PHI is located; it will advise you how to redirect your request.

If you believe that your PHI maintained by the Board contains an error or needs to be updated, you have the right to request that the Board correct or supplement your PHI. Your request must be made in writing to the privacy officer on your campus or in your facility. Your written request must explain why you desire an amendment to your PHI.

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

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

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

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

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

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

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

Effective Date: April 14, 2003

PLEASE NOTE:

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

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

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

CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

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

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

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

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

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

Purpose for disclosure: _____

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

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

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

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

___ Other (specify) _____

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

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

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

I understand that my institution or facility, the University System of Georgia, or the Board of Regents of the University System of Georgia assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release the Board of Regents of the University System of Georgia and its agents and employees from all legal liability that may arise from this authorization.

Name (please print): _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

Group No.: _____ Group Name: _____

Member ID Number: _____ Social Security Number: _____

Signed: _____

Date of Birth: _____ Date this Authorization Executed: _____

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

My relationship to such person is: _____

Signed: _____

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

FORM CREATED 29 JAN 03

FUTURE OF THE PLAN

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

EMPLOYMENT RIGHTS NOT IMPLIED

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

GLOSSARY OF TERMS

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

Acute Care

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

Balance Billing

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

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

Coinsurance

Coinsurance is the portion of the covered allowed charges that a member must pay, after he/she has met the appropriate deductible. If a healthcare plan covers 80% of the cost for a particular benefit, the member would be responsible for the remaining 20% of covered charges. The 20% of allowed charges, paid by the member, is deemed to be the *coinsurance* amount.

Contract Year

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

Co-payment

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

Covered Charges

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

Custodial Care

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

Deductible

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

Emergency Care

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

Eligible Charges

Eligible Charges are determined by: (a) the Claims Administrator'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 Participating and Non-Participating Providers is based on Eligible Charges for the type of service a Participant receives, for example, Hospital or Physician services.

Explanation of Benefits (EOB)

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

Hospice Care

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

Indemnity Plan

An *indemnity plan* is a type of healthcare plan that provides major medical coverage, including diagnosis and/or treatment of illness, injury or medical conditions. This type of healthcare plan allows a member the greatest flexibility in the selection of healthcare providers. The current claims administrator for the University System of Georgia's *indemnity plan* is Blue Cross Blue Shield of Georgia.

Inpatient

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

Lifetime Maximum Benefit

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

Medical Utilization Management

Medical Utilization Management is a program that is administered by BCBSGa for all inpatient, and for specific outpatient, medical/surgical treatments and diagnostic tests. To access benefits coverage, BCBSGa must determine if: (1) a procedure is medically necessary; and/or (2) if an appropriate and alternative treatment is available. For additional information, please see page 27 of this booklet.

Medically Necessary

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

Mental Health Disorders

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

Non-Covered Charges

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

Outpatient

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

Out-of-Pocket Limit (Stop Loss)

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

PHI (Personal Health Information)

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

Provider

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

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| <p><u>Disclaimer:</u> This booklet summarizes your indemnity healthcare plan. It is not intended to cover all the details of the indemnity healthcare plan. This booklet is not a contract and the benefits that are described can be terminated or amended by the University System of Georgia in its sole discretion. Should any questions arise, the master contract and the contract of the administration are the final authorities in determining benefits.</p> |
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LEGISLATION PASSED BY THE 2008 GEORGIA GENERAL ASSEMBLY AND SIGNED BY THE GOVERNOR

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

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

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