

THE INDEMNITY HEALTH BENEFITS PLAN



**THE UNIVERSITY SYSTEM
OF GEORGIA**

RESOURCE CONTACTS

Should you have questions regarding your indemnity health plan benefits, 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
Pre-certification for Specific Outpatient/All Inpatient Hospital Services	UNICARE	1-800-233-5765 TDD/1-800-368-4424
MEDCALL (For emergency room referral and for medical information from a registered nurse, 24-hours a day, seven days a week)	UNICARE	1-800-785-0006 TDD/1-800-368-4424
Disease State Management Program	UNICARE	1-800-858-4626 ext. 4661 TDD/1-800-368-4424
Organ and Tissue Transplant Program	UNICARE	1-800-828-6518
Pharmacy Benefit Program	Express Scripts, Inc.	1-877-650-9341 TDD/1-800-842-5754
HIPAA Coverage	Pension & Welfare Benefits Administration	US Department of Labor 61 Forsyth Street, SW Suite 7B54 Atlanta, GA 30303 404-562-2156

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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, 2001.

Your health benefits plan is designed with two important goals in mind. The primary purpose of the healthcare plan is to protect you and your family against financial hardship in the event of an illness or serious injury. Your indemnity healthcare plan will pay for most of the medically necessary costs associated with the treatment of covered illnesses and/or injuries experienced by you and/or your covered dependents.

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. Once you become familiar with the plan's provisions, it becomes 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 listed on the inside front cover.

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
<u>Maximum Lifetime Benefit</u>	\$2 Million
<u>Annual Deductible</u> <ul style="list-style-type: none"> • Individual • Family (3 or more covered members) 	\$300 \$900
<u>Maximum Annual Out-of-Pocket Limit (Stop Loss)</u> <ul style="list-style-type: none"> • Individual • Family 	\$2,000 \$4,000
<u>Pre-Existing Conditions</u>	None
<u>Physician Services Provided In An Office Setting</u> <ul style="list-style-type: none"> • Physician Office Visit <i>For treatment of illness or injury</i> 	80% of UCR charges for <u>non-surgical</u> services; subject to deductible.
<ul style="list-style-type: none"> • Wellness Care/Preventive Healthcare <i>Physical Exam, Mammogram, Pap Smear, Prostate Exam/PSA, Well-baby Care and Immunizations, Adult Immunizations, Routine Eye Exams, Routine Hearing Exams</i> 	\$500 per person per plan year; paid at 100% of UCR; not subject to deductible.

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS
<ul style="list-style-type: none"> • Laboratory Services <i>(Exclusive of Wellness Care/Preventive Care)</i> <i>X-ray, allergy testing, injectible medications, and diagnostic tests</i> <i>Pre-certification may be required for diagnostic tests.</i> 	80% of UCR charges; <i>subject to deductible.</i>
<ul style="list-style-type: none"> • Maternity Care <i>(Prenatal, Delivery and Postnatal)</i> 	90% of UCR charges; <i>subject to deductible.</i>
<ul style="list-style-type: none"> • Outpatient Surgery <i>Pre-certification may be required.</i> 	90% of UCR charges; <i>subject to deductible.</i>
<ul style="list-style-type: none"> • Allergy Shots & Serum 	80% of UCR charges; <i>subject to deductible.</i>
<ul style="list-style-type: none"> • Second Surgical Opinions <i>(Elective Surgery)</i> 	100% of UCR charges; <i>not subject to deductible.</i>
<ul style="list-style-type: none"> • Treatment of TMJ <i>(Temporomandibular Joint Disorders)</i> <i>Diagnostic testing & <u>non-surgical</u> treatment</i> 	80% of UCR charges; <i>subject to deductible.</i> Lifetime benefit limit of \$1,000.
<p><u>Inpatient Hospital Services</u></p> <ul style="list-style-type: none"> • Physician Services <i>Physician services may include surgery, anesthesiology, pathology, radiology, and/or maternity care/delivery.</i> <i>Pre-certification is required.</i> 	90% of UCR charges for surgeon; <i>subject to deductible.</i> 80% of UCR charges for anesthesiologist, pathologist, or radiologist services/consultations; <i>subject to deductible.</i>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS
<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><i><u>In-State Hospitals</u></i> 90% of contracted DRG rate; limited to semi-private room rate; <i>subject to deductible.</i></p> <p><i><u>Out-of-State Hospitals</u></i> 90% of UCR charges for service area; limited to semi-private room rate; <i>subject to deductible.</i> <i>Not subject to balance billing.</i></p>
<ul style="list-style-type: none"> Maternity Care <p><i>(Delivery)</i></p>	<p>90% of contracted DRG rate; <i>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 illness or injury.</i></p> <p><i>Pre-certification may be required.</i></p>	<p>90% of UCR charges; <i>subject to deductible.</i></p>
<ul style="list-style-type: none"> Hospice Care <p><i>Pre-certification is required.</i></p>	<p>90% of UCR charges; <i>subject to deductible.</i></p>
<p><u>Outpatient Hospital/Facility Services</u></p>	
<ul style="list-style-type: none"> Physician Services <p><i>Physician services may include surgery, anesthesiology, pathology, radiology, and/or maternity care/delivery.</i></p> <p><i>Pre-certification may be required</i></p>	<p>90% of UCR charges for surgeon; <i>subject to deductible.</i></p> <p>80% of UCR charges for anesthesiologist, pathologist, or radiologist services/consultations; <i>subject to deductible.</i></p>
<ul style="list-style-type: none"> Facility Selected by Treating Physician <p><i>Pre-certification may be required</i></p>	<p>90% of UCR charges; <i>subject to deductible.</i></p>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS
<ul style="list-style-type: none"> • Care in a Hospital Emergency Room (ER) <i>Treatment of an emergency medical condition or injury.</i> 	<p style="text-align: center;"><u><i>Surgical Services:</i></u> 90% of UCR charges, <i>if referred by MedCall; subject to deductible.</i></p> <p style="text-align: center;">80% of UCR charges, <i>if not referred by MedCall; subject to deductible.</i></p> <p style="text-align: center;"><u><i>Non-Surgical Services:</i></u> 80% of UCR charges, <i>if referred by MedCall; subject to deductible.</i></p> <p style="text-align: center;">70% of UCR charges, <i>if not referred by MedCall; subject to deductible.</i></p>
<ul style="list-style-type: none"> • Laboratory Services <i>X-ray, laboratory work, diagnostic testing. Provided in conjunction with treatment of illness or injury.</i> <i>Pre-certification may be required.</i> 	<p style="text-align: center;">80% of UCR charges; <i>subject to deductible.</i></p>
<ul style="list-style-type: none"> • Extended Care Facility <i>Pre-certification is required.</i> 	<p style="text-align: center;">90% of UCR charges; <i>subject to deductible.</i></p>
<ul style="list-style-type: none"> • Home Nursing Care <i>Pre-certification is required.</i> 	<p style="text-align: center;">90% of UCR charges; <i>subject to deductible.</i> No plan year limit.</p>
<ul style="list-style-type: none"> • Home Hyperalimentation <i>Pre-certification is required.</i> 	<p style="text-align: center;">90% of UCR charges; <i>subject to deductible.</i></p>
<ul style="list-style-type: none"> • Hospice Care <i>Pre-certification is required.</i> 	<p style="text-align: center;">90% of UCR charges; <i>subject to deductible.</i></p>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS
<ul style="list-style-type: none"> • Cochlear Implants <i>Pre-certification is required.</i> 	90% of UCR charges; <i>subject to deductible.</i>
<ul style="list-style-type: none"> • Ambulance Services <i>For medically necessary emergency transportation only.</i> 	80% of UCR charges; <i>subject to deductible.</i>
<ul style="list-style-type: none"> • Durable Medical Equipment <i>Plan may require approved Letter of Medical Necessity.</i> 	80% of UCR charges; <i>subject to deductible.</i>
<ul style="list-style-type: none"> • Outpatient Short Term Rehabilitation Services 	80% of UCR charges; <i>subject to deductible.</i> Maximum of 12 consecutive weeks per incident for physical/occupational therapy; maximum of 12 weeks per incident for cardiac therapy; no limitation for speech therapy.
<p><u>Disease State Management Training & Education Services</u> <i>Pre-certification is required.</i></p>	100% of vendor negotiated rates; <i>not subject to deductible.</i>
<p><u>Pharmacy Benefit Manager</u> <i>Vendor: Express Scripts, Inc.</i></p>	<p>3-Tier Co-payment Structure Generic: \$10 co-payment Preferred Brand Name: \$20 co-payment Non-Preferred Brand Name: 20% co-payment of non-preferred name brand drug cost; minimum member co-pay \$35/maximum member co-pay of \$75.</p>

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><u>Inpatient</u> 90% of UCR 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> 80% of UCR charges; subject to deductible. Maximum benefit coverage of 20 visits per person per plan year.</p> <p>UNICARE may approve up to 50 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><u>Organ and Tissue Transplants</u></p> <p><i>Pre-certification is required.</i></p> <p><i>Expenses related to donor search are not covered.</i></p>	<p>90% of vendor network rate at a UNICARE contracted transplant center; subject to deductible <u>and</u> separate \$100 hospital deductible.</p> <p>60% of UCR charges at a non-contracted UNICARE transplant center; subject to deductible <u>and</u> separate \$100 hospital deductible.</p> <p>Lifetime benefit limit of \$500,000.</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 three levels of coverage:

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

DEPENDENT COVERAGE

When an employee elects “*Employee + One*” coverage 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;
- 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 legal guardian if:
 - A court has named the employee as the guardian for the child’s “*person and property*”;
 - *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 31 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 + one*” 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 + one*” 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 31 days from your effective date of employment to enroll for coverage in a healthcare plan. If you enroll in a healthcare plan within 31 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 31 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 31 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, which 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 31 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 31 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 31 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.

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 + one, or family). Members who have COBRA coverage will have the same open enrollment period and options.

USG RETIREE ANNUAL CHANGE PERIOD

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

A University System retiree will not have the opportunity to participate in the annual change period unless he/she elected to take healthcare coverage into retirement. During the annual retiree change period, an eligible retired employee may elect to: (1) drop healthcare coverage; (2) participate in a different healthcare plan option; and/or (3) reduce his/her level of coverage. For example, an eligible retiree may reduce his/her level of healthcare coverage from “family” coverage to “employee + one” coverage; from “family” coverage to “single” coverage; or from “employee + one” coverage to “single” coverage.

A retiree is not permitted to add healthcare coverage or to increase the level of coverage carried into retirement, during an annual change period.

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 are 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 + one, 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*. In the previous edition of this document, the terminology “*change in family status*” was used, rather than “*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; or (Please see the example on the next page.)

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 + one*” effective October 1. The spouse, employed by XYZ, must provide documentation/certification to the USG that he/she has lost healthcare coverage with XYZ.

- Qualified Medical Child Support Order (QMCSO)

A court-ordered qualified medical child support order (QMCSO) results from a divorce, legal separation, annulment, or change in legal custody. A QMCSO 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 31 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 31 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.

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.*

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 incurs for the remainder of the plan year.

Just as with the family annual deductible, family maximum annual out-of-pocket limits 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 35);
- Expenses for medical services in which the member fails to comply with the Medical Utilization Review Program requirements (page 20);
- Expenses for covered medical services that exceed the usual, customary and reasonable (UCR) contracted amounts (page 16);
- Expenses for medical services exceeding other plan limits;
- Expenses for incurred medical services that exceed the maximum lifetime benefit of \$2 million (page 15);
- 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 43); and
- Member co-payments for prescription drugs.

MAXIMUM LIFETIME BENEFIT

The maximum lifetime medical benefit under the indemnity healthcare plan is \$2,000,000 per person.

Covered charges incurred by a covered member for TMJ, 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, 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. ***Pre-certification by UNICARE 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 by UNICARE is required.***
 - *Outpatient*: Maximum benefit coverage of 20 visits per person per plan year. UNICARE 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/VENDORS

The current administrative agents or vendors for the University System of Georgia indemnity healthcare plan include:

(A) Wellpoint/Blue Cross Blue Shield of Georgia

- Provides customer service/provides claims administration services.

(B) Wellpoint/UNICARE

- Provides pre-certification for specific outpatient and all inpatient hospital services;
- Provides case management services;
- Provides access and education regarding disease state management programs (diabetes, asthma, congestive heart failure, and oncology);
- Provides access for organ and tissue transplant network centers; and
- Provides access to MedCall member services.

(C) Express Scripts

- 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, 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 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. 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.

- **Diagnostic Related Group (DRG) rates:** The Georgia Department of Community Health (DCH) negotiated direct contracts with the majority of acute care hospitals located within the State of Georgia. These direct contracts established the rates that would be paid for medical services associated with hospital inpatient care. Payment for services is based upon a negotiated Diagnostic Related Group (DRG) rate. DRG rates are, therefore, based upon the specific diagnosis and type of treatment provided for the patient.

- ***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

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. In addition, a participating physician will prepare and file all of your medical claims for you. ***Plan benefits are paid directly to participating physicians.***

Physicians who are eligible to participate in this BCBSGA program 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 to accept the indemnity plan's UCR fee limit as the maximum payment amount for his/her professional services. This means that you may be subject to balance billing.

To determine if your doctor is a BCBSGA participating physician, please ask him or her. When visiting a new physician, or when being referred to a specialist, it is wise to check in advance to see if he/she is a BCBSGA participating physician. Information regarding the physicians who participate in this program may be determined by contacting the BCBSGA Customer Service telephone number. This telephone number is listed on your indemnity plan identification card. You may also determine if your BCBSGA doctor is a participating physician by visiting the University System of Georgia website at www.usg.edu/admin/humres/benefits/health/.

WELLNESS CARE/PREVENTIVE HEALTHCARE

The indemnity plan will provide wellness benefits of up to \$500 per person per plan year. The wellness benefit is paid at 100% of UCR and is not subject to a member deductible. Charges for wellness services in excess of the annual \$500 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 type 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.

BlueChoice Vision Program

Blue Cross Blue Shield of Georgia (BCBSGA) has established a member-discounted vision care services contract with LensCrafters (excluding LensCrafters Optiques) and with a number of independent optometrists throughout the State of Georgia, called the ***BlueChoice Vision Program***. By using this program you will save costs for vision exams, contact lenses, and eyeglasses. 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 University System of Georgia website at www.usg.edu/admin/humres/benefits/health/. Please be informed that the ***BlueChoice Vision Program*** is a vision services discount program, not an employee benefit. This program is subject to change or termination at anytime.

HOSPITAL INPATIENT CARE DIAGNOSTIC RELATED GROUP (DRG) RATES

In the latter part of 1999, the Georgia Department of Community Health (DCH) negotiated direct contracts with the majority of acute care hospitals located within the State of Georgia. These direct contracts established the rates that would be paid for medical services associated with hospital inpatient care. Payment for services is based upon a negotiated Diagnostic Related Group (DRG) rate. DRG rates are, therefore, based upon the specific diagnosis and type of treatment provided for the patient.

When this initial contract was executed, there were in excess of 160 State of Georgia acute care hospitals that agreed to accept the DRG rate structure proposed by DCH. The number of State of Georgia DRG-contracted hospitals may change. Each hospital maintains an individual contract with the Department of Community Health.

As a cautionary note, please be informed that any State of Georgia acute care hospital may choose to terminate its respective DRG contract with DCH. We encourage you to check with your hospital, prior to admission, and determine if it continues to maintain its DRG contract with the Department of Community Health. If your hospital does not participate in the direct contract with the Department of Community Health, hospital inpatient services will process under UCR.

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 UCR 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 by UNICARE to receive plan benefits.

Decisions regarding an elective surgery will continue to be the joint responsibility of the member you 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 UNICARE, 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, UNICARE 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 UNICARE pre-certification, please review the section entitled, “*Pre-certification for Certain Outpatient Procedures*”, located on page 23.

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, UNICARE must determine if: (1) the procedure 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, UNICARE will monitor a patient’s progress by consulting with his/her attending physician. UNICARE will consult with the attending physician to ensure that the recommended treatment plan is consistent with medical benefits covered by the healthcare plan design. UNICARE will, also, review and render decisions for requests to extend periods of inpatient hospital/medical facility confinement.
- ***Available Alternative Medical Services/Care Review Process*** - UNICARE will identify patients for whom early discharge from a hospital/medical facility to a home healthcare environment is appropriate. UNICARE 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 UNICARE.

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

- Hospital confinements, including emergency room admissions, maternity 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; and
- Private duty nursing.

PLEASE NOTE: A member must contact UNICARE a minimum of 48 hours before an elective surgery. Anyone may contact UNICARE on behalf of the member, but it will be the member's responsibility to ensure that UNICARE is notified regarding elective surgery prior to his/her hospitalization.

For failure to comply with the inpatient and outpatient Medical Utilization Management Review requirements, a \$200 penalty may be assessed. The \$200 penalty will not apply to your maximum annual out-of-pocket limit. In addition, your benefit coverage may be denied for any treatment that you receive that is not deemed to be medically necessary.

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 of UNICARE, no plan benefits will be paid.***

MATERNITY AND NEWBORN INFANT NURSERY CARE BENEFITS

After meeting your deductible, the plan will pay 90% of UCR for all covered charges associated with prenatal, delivery and postnatal maternity care. The plan will pay for 90% of the contracted DRG rates for 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 will be shared with UNICARE. The recommended treatment plan must be reviewed and approved by UNICARE. 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

Certain outpatient procedures and diagnostic tests will require pre-certification. As soon as your physician recommends an outpatient procedure for you or for a covered dependent, please ask your doctor to provide you with the CPT code for that procedure. You may then contact the UNICARE 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 the procedure requires pre-certification, you must call the Medical Utilization Management Review program at least two business days 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:

CAT or CT Scans (computerized axial tomographies), **except brain and spine**

70480 through 70492; 71250 through 71270; 72192 through 72194; 73200 through 73202; 73700 through 73702; 74150 through 74170; 76375; 76380

Colonoscopies

45378 through 45385

Endoscopies

43234; 43235; 43239

Esophageal Surgeries

43280; 43289; 43324; 43325

Laparoscopies and/or Peritoneoscopies

47562; 47563; 47564; 49320; 49321; 49322; 49329; 58550; 58551; 58578; 58579; 58660; 58661; 58662; 58679

MRAs (magnetic resonance angiographies)

70541; 71555; 72159; 72198; 73225; 73725; 74185

MRIs (magnetic resonance imaging)

70336; 70540; 70551 through 70553; 71550; 72141 through 72158; 72196; 73220; 73221; 73720; 73721; 74181; 75552 through 75556; 76093; 76094; 76400

Nasal Surgeries

30130; 30140; 30400 through 30520; 30620; 30801; 30802; 30930

Sleep Studies

95805; 95806; 95807; 95808; 95810; 95811

Uvulopalatopharyngoplasties

42120; 42140; 42145; 42299; 42950

For failure to comply with the inpatient and outpatient Medical Utilization Management Review requirements, a \$200 penalty may be assessed. The \$200 penalty will not apply to your maximum annual out-of-pocket limit. In addition, your benefit coverage may be denied for any treatment that you receive that is not deemed to be medically necessary.

PLEASE NOTE: 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 UNICARE, 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. UNICARE 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 UNICARE when a member experiences a catastrophic illness or injury.

EXTENDED CARE FACILITY

After meeting your deductible, the plan will pay for 90% of covered charges for extended care facility services. ***UNICARE 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 covered charges for home healthcare services. ***UNICARE 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: (1) a maximum of **12 consecutive weeks per incident for physical/occupational therapy**; and (2) **no limitation for speech therapy**.

To receive a benefit for **speech therapy**, there must be a demonstrated 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 a UNICARE-approved home healthcare plan;
- Custodial care;
- Services provided by a family member; and
- Services or supplies that are 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 UCR charges for ***basic*** equipment. The benefit for ***deluxe*** equipment, including prosthesis, will be limited to the UCR 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 UNICARE. UNICARE will determine if the recommended DME meets the plan criteria for medical necessity and/or requires pre-certification. UNICARE will make such decisions on a case-by-case basis. Please contact UNICARE 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;
- Heating pads, hot water bottles, home enema equipment, or rubber gloves;
- Electric toothbrushes; and
- Home supplies, such as first aid items.

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 covered charges for hospice care services. ***UNICARE 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.

DISEASE STATE MANAGEMENT PROGRAM

The Disease State Management (DSM) program, administered by UNICARE, provides educational assistance to members with chronic disease. The DSM program is *voluntary* and strictly confidential. The program assists participants with managing their chronic medical condition by providing educational information and intervention strategies. Program participants are encouraged to work with their personal "case manager" and their attending physician to prevent potential side effects and complications from the chronic disease. The case manager is an experienced registered nurse (RN) who, with guidance from the treating physician, provides patients with informational resources to improve their quality of life.

The DSM program includes participant information regarding *Diabetes, Asthma, Oncology and Congestive Heart Failure*. Through participation in a DSM program, a member will become knowledgeable about his/her chronic disease, his/her physician-prescribed medical treatment plan, and the means to assist with managing/monitoring his/her chronic condition. The goals of the DSM programs are to: (1) improve member recognition of chronic disease warning signals; (2) improve early detection and management of symptoms; (3) promote optimal use of medical therapy; and (4) improve patient compliance with prescribed treatment plans.

UNICARE will identify members, who may be appropriate candidates, to participate in this *voluntary* program through various means. These means may include, but not be limited to, the following:

- A candidate's medical history and related claims experience;
- A review of emergency room treatment/hospitalization claims experience and/or pre-certification reviews by UNICARE;
- Referral by MedCall of a member to the DSM program; and
- Member inquiries regarding access and participation in the DSM program.

Should you desire additional information or should you wish to participate in one of the DSM programs, please call UNICARE at 1-800-858-4626 ext. 4661/TDD 1-800-368-4424.

MEDCALL PROGRAM

MedCall 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 MedCall telephone number is 1-800-785-0006/TDD 1-800-368-4424.

Hospital Emergency Room Care - MedCall nurses have the authority to issue hospital emergency room referrals. Emergency room referrals by MedCall will result in a higher level of benefit coverage for the member. If an emergency room referral is obtained from MedCall, 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 MedCall, 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.

If admitted to a hospital, the member must contact UNICARE within 2 business days after the admission. The toll-free telephone number for UNICARE is 1-800-233-5765/TDD 1-800-368-4424. Failure to contact UNICARE within 2 business days may result in a \$200 member penalty.

The use of MedCall 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 MedCall to obtain timely emergency medical assistance.

The MedCall *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 MedCall 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 MedCall audio library information is available on the University System of Georgia website at www.usg.edu/admin/humres/benefits/health/. The resource link is *Healthwise Knowledgebase*.

ORGAN AND TISSUE TRANSPLANT PROGRAM

The UNICARE 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 UNICARE physicians and members of the UNICARE 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 UNICARE 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 UNICARE contracted transplant center is used. There will be an additional and separate \$100 hospital deductible required from the member, if this benefit is used.

Please be advised that organ and tissue transplants are covered at 60% of UCR charges at a non-contracted UNICARE transplant center. There will be an additional and separate \$100 hospital deductible required from the member, if this benefit is used.

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

The lifetime maximum benefit limit for the *Organ and Tissue Transplant* program is \$500,000. Expenses related to donor search are not covered under the plan.

COVERED EXPENSES

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

Inpatient Hospital Services – 90%

After meeting your deductible, the plan will pay for 90% of the contracted DRG rates for covered inpatient hospital services rendered within the State of Georgia and for 90% of UCR 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 tests/examinations;
- Physician charges for assisting in 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 UNICARE contracted transplant center. There will be an additional and separate \$100 hospital deductible required from the member, if this benefit is used.

Please be advised that organ and tissue transplants are covered at 60% of UCR charges at a non-contracted UNICARE transplant center. There will be an additional and separate \$100 hospital deductible required from the member, if this benefit is used.

Inpatient Hospital Services – 80%

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

- Emergency room **surgical** services, if a referral to the emergency room is obtained from MedCall;
- Physician charges for **surgical** procedures;
- **Surgical** charges associated with the removal of impacted teeth;
- Cochlear implants;
- An outpatient surgical facility selected by a treating physician;
- 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 UCR 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 MedCall;
- Laboratory charges, including x-rays and diagnostic tests/examinations;
- Ambulance service, if medically necessary, to the nearest facility providing the required treatment; and
- Outpatient short-term rehabilitation services. Your benefit provides for: (1) a maximum of **12 consecutive weeks per incident for physical/occupational therapy**; (2) a maximum of **12 weeks per incident for cardiac therapy**; and (3) **no limitation for speech therapy**.

To receive a benefit for **speech therapy**, there must be a demonstrated 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 UCR charges for:

- Wellness care/preventive healthcare (limited to \$500 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 UCR charges for:

- Outpatient surgery provided in a physician office setting;
- Removal of impacted teeth, other than partially erupted teeth; and
- Maternity care (prenatal and postnatal).

Physician Services Provided in an Office Setting – 80%

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

- A physician's office visit for non-surgical services;
- Laboratory charges, including x-rays and diagnostic tests/examinations (exclusive of wellness care/preventive healthcare);
- Allergy 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 a UNICARE approved hospital. ***Pre-certification for inpatient mental health and substance abuse treatment services by UNICARE 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. UNICARE 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 UNICARE approved hospital means a hospital, an outpatient treatment facility, or a residential treatment facility. A convalescent nursing home is not deemed to be a UNICARE 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.

THE BCBSGA PRUDENT BUYER PROGRAM FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES

One of the features that is included in the indemnity healthcare plan to help reduce your out-of-pocket costs is the Prudent Buyer Program. Similar to the 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. The Prudent Buyer Program applies to both inpatient and outpatient mental health facility treatment services.

It is always your choice to select or use a mental health facility that *is* or that *is not* a part of the Prudent Buyer Program. Please be informed that if you select a mental health facility that *is not* a participant in the Prudent Buyer Program, you may be subject to balance billing for mental health and substance abuse treatment services that are provided.

To determine if a mental health facility is a member of the BCBSGA Prudent Buyer Program, please ask the facility administrator. It is wise to check with the mental health facility in advance of receiving treatment services. Information regarding the mental health facilities that are participants in the Prudent Buyer Program may be determined by contacting the BCBSGA Customer Service telephone number at 1-800-424-8950/TDD 404-842-8073.

PHARMACY BENEFIT MANAGEMENT (PBM) PROGRAM

Express Scripts, Inc., 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 and your physician select.

Co-Payment For	Participating Retail Pharmacy 30-Day Supply
Generic Drugs	\$10.00
Preferred Brand Name Drugs	\$20.00
Non-Preferred Name Drugs	20% with a \$35.00 minimum and a \$75.00 maximum

The use of generic prescription medications, whenever available, is the most cost effective option for a member. Several communication pieces have been mailed to plan members to explain the details regarding the pharmacy benefit program (March 2001 and June 2001).

There are two Express Scripts resources available to assist you, your pharmacist, and/or your physician with questions regarding the University System of Georgia pharmacy benefit program. You may contact Express Scripts, 24-hours a day, seven days a week, by calling the toll free customer service telephone number at 1-877-650-9341/TDD 1-800-842-5754. You may also obtain information by going to the University System of Georgia website address at www.usg.edu/admin/humres/benefits/health.

Among the types of information that are available on the University System of Georgia website are the location of Express Scripts participating network pharmacies within the State of Georgia; the Board of Regents preferred drug list; and the Board of Regents prescription drug benefit plan. Please be reminded that prescription drug member co-payments will not apply to your medical plan annual deductible or out-of-pocket maximum.

There will be no Coordination of Benefits (COB) for allowed pharmacy charges between the Board of Regents pharmacy plan and any other pharmacy/medical plan in which the member may be enrolled.

PLEASE NOTE: For additional detailed information regarding your prescription drug benefit program, please refer to your ***June 2001 Pharmacy Benefit Program*** member handbook.

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 by UNICARE);
- 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;
- 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 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; 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 autistic disease of childhood, 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;
- Those for smoking cessation programs;
- Those for dental work, dental X-rays, or dentures, unless the procedure resulted 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.

<p>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).</p>
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WHEN INDEMNITY HEALTHCARE PLAN COVERAGE FOR YOUR ELIGIBLE AND COVERED DEPENDENT(S) ENDS

Your indemnity healthcare plan coverage for your eligible and covered dependents will end on the last day of the month in which:

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

- You elect to reduce your level of benefit coverage: (1) from “*family*” coverage to “*employee + one*” coverage or to “*single*” coverage; or (2) from “*employee + one*” 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 this page, or the section entitled, “***Extended Coverage for Your Dependents After Your Death***”, located on page 39 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 (family, employee + one, or single) of healthcare coverage that he/she had immediately prior to retirement.

On page 11 of this booklet, information is provided regarding the ***USG Retiree Annual Change Period***. Please be reminded that once a member has entered retirement, the member will not be permitted to add healthcare coverage or to increase the level of coverage that he/she carried into retirement.

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 + one*” 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.

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 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 of the indemnity plan for no more than 24 months after the death of the employee. The University System of Georgia will pay the employer portion of the healthcare plan premiums for this 24-month period. After the 24-month period, healthcare coverage may be continued; but the University System of Georgia will discontinue contributions for premium costs.

FILING PAPER CLAIMS/USE OF A PHYSICIAN WHO IS NOT A MEMBER OF THE BCBSGA PARTICIPATING PHYSICIAN PROGRAM

If you receive medical care from a physician who is not a member of the BCBSGA Participating Physician Program, you will have two years from the date that such service was rendered to file a paper claim and receive reimbursement for covered charges. Claims should be submitted to:

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

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; and
 - The signature of the provider.

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 Resource/Personnel Office, from the BCBSGA Customer Service department, or via electronic format from the University System of Georgia website, www.usg.edu/admin/humres/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 two years 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:

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

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 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 coverages 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. If you continue to be dissatisfied with the BCBSGA written conclusions, you may submit a second written appeal. Any additional member/provider supporting documentation should be included with this second appeal.

BCBSGA will acknowledge receipt of your second written appeal *within 5 business days*. At the conclusion of the review process for a second written letter of appeal, BCBSGA will issue its final written decision.

5. At the second level of appeal, you will have an opportunity to represent yourself before a formal BCBSGA Grievance Committee. You will be permitted to present your concerns before this committee and attempt to satisfactorily resolve your issue. Should you submit a request to address the BCBSGA Grievance Committee, you will not be permitted to be accompanied by personal legal counsel.

6. 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.

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;
- Mental health hospitals participating in the BCBSGA Prudent Buyer Program;
- State of Georgia DRG contracted hospitals; and
- Centers of Expertise participating in the UNICARE national *Organ and Tissue Transplant* program.

SUBROGATION

The indemnity healthcare plan includes a subrogation clause. If a covered member incurs medical expenses for an injury or illness involving alleged negligence/misconduct of another party, BCBSGA may have a claim against the other party for payment of a covered member's medical bills. BCBSGA can seek to recover the cost of a member's medical treatment/services incurred by the plan for such expenses. BCBSGA can seek recovery of associated medical costs from either the member or from a third party. The member will be responsible for providing BCBSGA with any information or assistance needed to enforce this provision.

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 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 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

Under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you or your covered dependents have the option of continuing healthcare coverage under the USG indemnity healthcare plan. Terms, conditions, and costs for healthcare coverage are identified below. If your coverage is continued under COBRA, UNICARE 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.

You may elect COBRA coverage under the following conditions:

- 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.

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

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

PLEASE NOTE: It is the member's responsibility to notify his/her campus Human Resources/Personnel Office 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 dependents to be eligible to participate in COBRA healthcare coverage.

It is, also, the member's responsibility to notify his/her campus Human Resources/Personnel Office when there is a change in the member's or in the member's covered dependents' COBRA eligibility status.

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; or
- The University System of Georgia healthcare plan is terminated.

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. These charges do not apply to the plan's stop-loss limits or deductibles.

Coinsurance

Coinsurance is the share of covered charges that a member must pay, after having met the appropriate deductible. If a healthplan covers 80% of the cost for a particular benefit, the member would be responsible for the remaining 20% of covered charges. The 20% of covered 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 runs from January 1 through December 31.

Copayment

A fixed dollar amount that must be paid by the member for a particular service or item, such as the *copayment* for the pharmacy benefit program.

Covered Charges

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

Deductible

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

Medical care provided for a sudden, severe, and/or unexpected illness/injury which, if not treated immediately, could be life threatening or result in permanent impairment of bodily functions.

Explanation of Benefits (EOB)

An itemized statement of member-incurred medical charges. An *EOB* will identify paid or denied provider charges, resulting from the filing of a healthcare claim.

Hospice Care

Medical care provided in an inpatient or outpatient setting, where a physician has certified that a patient is terminally ill. The life expectancy of a hospice patient is generally deemed to be six months or less.

Indemnity Plan

A healthcare plan, which 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 USG 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 at least for a period of 24 hours.

Lifetime Maximum Benefit

The *lifetime maximum benefit* is \$2,000,000. The *lifetime maximum benefit* reflects a cumulative total of all covered 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 healthcare plan contracts.***

Medical Utilization Management

A program administered by UNICARE for all inpatient and for specific outpatient medical/surgical treatment and testing. To access benefits coverage, UNICARE 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 20 of this booklet.

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)

The maximum amount of healthcare plan expenses paid by the member during a plan year. Out-of-pocket expenses include member deductibles and co-insurance payments. 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.

Provider

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

Disclaimer: 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.

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