BlueCross BlueShield Healthcare Plan of Georgia

BlueCross BlueShield of Georgia

Benefits You Can Count On

Morehouse School of Medicine
Blue Open Access POS/Dental/Vision
Member Guide

Choosing the right plan is a very personal thing.

Use this book to find one that's

- Right for your lifestyle
- Right for your needs
- Right for your peace of mind

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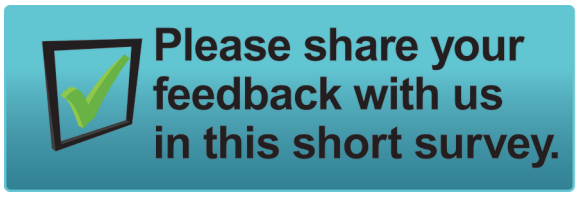
Please share your
feedback with us
in this short survey.

Your guide to Blue Cross and Blue Shield of Georgia benefits

Welcome! We're so glad you're taking time to check out all that Blue Cross and Blue Shield of Georgia (BCBSGA) has to offer you. Choosing your health care plan (and the benefits that go with it) is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with our BCBSGA plan. It shows what's available to you, what you get with each benefit and how the plan works.

Explore the advantages of being a BCBSGA member.

This booklet goes into all the advantages. But here are the top four:

1. **You're covered even when travel away from home.** You have access to the BlueCard® program and the BlueCard Worldwide® program so you'll be able to find an in-network doctor or hospital across the country or around the world if you need care. Wherever you travel, you can have peace of mind knowing you're covered.
2. **You get more than just basic coverage.** You get access to tools, resources and guidance that are personalized just for you. Plus there are programs to help you get and stay healthy, some are even online. They'll help you reach your personal goals to be as healthy as possible.
3. **There's so much you can do on our website – after all, it was created just for you.** If you have questions, you'll find the answers you're looking for. You can:
   - Order and print out a new member identification (ID) card if you lose yours,
   - Check the status of a claim
   - Find out how much a service costs
   - Search for a doctor, specialty, hospital or other health care professional
   - Learn about hundreds of health and wellness topics
   - And much more
4. **Finding an in-network doctor, specialist, hospital or a list of your medicines is a snap.** Just go our website and search the Online Provider Directory. Or call the Customer Service number on your member ID card. A customer service representative can give you information by phone, e-mail, fax or mail.

Once you get your member ID card, all it takes is three simple steps to discover the world of bcbsga.com.

- Go to bcbsga.com
- Click on Register
- Create your user name and password

Then you're ready to go!

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Your guide to Blue Cross and Blue Shield of Georgia benefits (continued)

We're on Facebook, Twitter and YouTube.

Did you know, that when you take better care of yourself, those around you will, too? Your health influences family, friends, even neighbors. (Studies prove it.) We're committed to helping you improve your health, wherever you go. And since you connect with friends, family, and coworkers – night and day, we've made it easy for you to connect with us.

Connect with Bob Harper from the television show *The Biggest Loser*.

We've teamed up with Bob Harper from the television show The Biggest Loser. Join us on the sites below for health, wellness and motivational ideas.

- Facebook.com/HealthJoinIn
- Twitter.com/HealthJoinIn
- YouTube.com/HealthJoinIn

How to choose a health care plan that's right for you

Choosing the health care plan that's right for you and your family can be a tough decision. There are so many options and so many words, phrases and abbreviations to learn. And while it can be quite confusing, it's important that you take the time to learn all you can so you can make the best choice to meet your specific needs. The plan you choose will make a difference in how much you spend on your health care during the year. That's why we suggest you take your time to carefully think about your needs and options. And we're here to help.

Ask these questions when choosing a health care plan:

Does the plan:

- Have special programs to help you if you suffer from asthma, diabetes or other ongoing conditions?
- Cover physical exams, shots and health screenings to help you stay healthy and avoid a health problem?
- Give you information such as brochures, newsletters or online tools about healthy living?
- Offer tools to help you manage your health, as well as your benefits?
- Offer discounts on goods and services to improve your health?

Learn about the Blue Cross and Blue Shield of Georgia difference

At Blue Cross and Blue Shield of Georgia, we put our members first. We're dedicated to helping them get and stay healthy. Visit bcbsga.com to learn more about all we have to offer – from our large, strong networks to our personal health programs to the many ways we can help you save money while getting as healthy as possible.

Know the basic differences between the types of plans.

You may have a choice of health care plans at work or within your family. Knowing how the different plans work will help you pick the plan that best fits your family needs and budget.

- **Health Maintenance Organization (HMO)** — gives you access to a wide-range of services with low copays and low out-of-pockets costs. An HMO gives you coverage only for the doctors, hospitals and other health care professionals (providers) that are in the plan's network. But by staying in-network, you save the most money. You must choose a PCP who gives general care and will give you referrals when you need to see specialists. When you choose an HMO, make sure the plan has a big network so your own doctor will most likely be in it.
- **Point-of-Service (POS**) — gives you coverage that's similar to both an HMO and a PPO. You're covered when using both in-network and out-of-network providers. But you have to choose a Primary Care Physician (PCP). That doctor helps direct all your care (he or she is your first point of service) and gives you referrals when you need to see other doctors. Like other plans, you'll save the most money when you stick with doctors that are in-network.

How to choose a health care plan that's right for you (continued)

- **Preferred Provider Organization (PPO)** — gives you coverage for doctors and hospitals that are in-network and out-of-network. This type of plan is different from a POS because you don't need to choose a PCP and you don't need any referrals.
- **Consumer-driven Health Plan —** gives you a variety of solutions ranging from plans that are only slightly different than those listed above to bold, new funding arrangements.

Here are some definitions:

Deductible: The amount you must pay each year before your plan pays anything. There may be a deductible for health care and a separate one for prescription drugs. Not every plan has a yearly deductible.

Coinsurance: An amount that you pay after you have met your plan's deductible. The plan pays a certain amount and you pay a certain amount.

Copay: The amount that you pay each time you see a doctor, get a prescription filled or get other services. A copay is a flat fee, like $20 for a doctor visit. Most HMOs have co-pays.

Understand the total costs.

Health care plans differ in many ways but with every plan, there's a basic premium, which is how much you and your employer each pay to buy the plan's coverage. The premium may only be a small part of your total cost. There are other payments you may make, which vary by plan. When choosing a plan try to figure out what the total cost is to you and your family, especially if someone in your family has a chronic or serious health condition.

Think about the following:

- Are there deductibles you must pay before the plan begins to help cover your costs?
- Are there office visit, emergency room or inpatient hospital copays?
- What is the coinsurance, meaning what part of the cost for other services do you have to pay out of your own pocket? If you use doctors that are out-of-network, how much more will you have to pay to get care?

To see the types of costs that come with our different health care plans, take a look at the Summary of Benefits. Your benefits manager can get you a copy for each type of plan if you don't already have one.

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Your Health Benefits

Blue Open Access POS

The trend these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how the plan works.

Straightforward coverage with a simple copay, and no referrals required.

One, you have options. Blue Open Access POS is a point-of-service plan, which means you have the flexibility to choose doctors in or out-of-network. Of course, in-network care will usually cost less than out-of-network care. You also have the added bonus of seeing these doctors without the need of a referral.

Two, as a Blue Cross Blue Shield Healthcare Plan of Georgia member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions — for you, your health and your budget.

Blue Open Access POS at a glance

- *Primary care physicians (PCPs):* No required, but recommended
  You can make your own decisions about your doctors, your care and your costs. A PCP can provide preventive care, coordinate care you get from specialists, and help you make decisions about your health.
- *Referrals:* Not needed
  You choose who you want to see. Makes getting second opinions very easy.
- *Claim forms:* No claim forms to submit when using network providers.
- *Out-of-network benefits:* Available, but at lower coverage levels than in-network
  We've negotiated special rates with independent doctors and hospitals in our network on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.
- *Out-of-pocket:* We keep your payment simple. If you stay in-network, you pay a copay — a fixed dollar amount — for care you receive. After that, most covered services are covered at 100%. If you go out-of-network, you may have to pay deductibles and coinsurance too. See your Benefit Summary to see what these payments will be.

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency, urgent or approved follow-up care, you have three options. Go to bcbsga.com, call BlueCard® Access at 800-810-2583 or call the customer service number on your member ID card.

This is a brief overview of your plan's features. Your Benefit Summary contains the details. See your benefits manager if you need a copy.

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Blue Open Access POS (continued)

You're getting more than a health plan

You get programs to actually help you manage your health. 360° Health® health management programs and Special Offers are available through bcbsga.com. The programs are explained in detail in this booklet.

Online Provider Finder

Finding your doctor is quick and easy

Simply follow these easy steps:

1. Go to bcbsga.com.
2. Select "Find a Doctor" and choose "Go".
3. Then, to find a doctor, hospital, or other health care provider and a map with directions, simply follow the steps outlined on the screen.

The directory allows you to search for both doctors and health care facilities. You can even make your search more specific by choosing a specialty or entering the name of a doctor or a facility.

Once you've entered the required information, you will see a list of doctors or facilities that matches your search criteria.

Mobile Provider Finder

Now you can search for a health care provider from your Web-enabled cell phone BlackBerry™, PDA or similar handheld device. It's called the Mobile Provider Finder — and it's the perfect alternative for those on the go!

From your Web-enabled device:

1. Visit www.bcbsga.com/mobile.
2. Choose the Mobile Provider Finder link.
3. Choose your plan and follow the screen instructions to continue with your search.

Don't have access to a computer or a Web-enabled device? Need more than the selection of providers found in this booklet? Call the customer service number on your ID card. The customer service representative can help you locate a doctor or facility.

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Blue Open Access POS
Morehouse School of Medicine Benefit Summary

All benefits are subject to the benefit period deductible, except those with in-network copayments, unless otherwise noted.
All benefit period maximums are combined between in-network and out-of-network.
In addition to copayments, members are responsible for deductibles and any applicable coinsurance.
Members are also responsible for all costs over the plan maximums.
Some services may require pre-certification before services are covered by the Plan.
Visit and day limit accumulation begins after the deductible is satisfied.

When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles and/or applicable coinsurance.

Deductibles, Coinsurance and Maximums	In-network Benefit Level	Out-of-Network Benefit Level
Benefit Period Deductible *		
▪ Individual	$250	$500
▪ Family	$750	$1,500
Coinsurance	Member pays 20% Plan pays 80%	Member pays 40% Plan pays 60%
Benefit Period Out-of-Pocket Maximum* (includes benefit period deductible)		
▪ Individual	$3,000	$6,000
▪ Family	$9,000	$18,000
Lifetime Maximum	Unlimited	Unlimited

*Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member's deductible amount also goes toward the Family deductible and out-of-pocket maximum. Not everyone has to meet his or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses.
The following do not apply to out-of-pocket maximums: copayment amounts, non-covered items and any member cost shares for pharmacy services.

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Preventive Care Services for Children and Adults (preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits) ▪ Well-child care, immunizations ▪ Periodic health examinations ▪ Annual gynecology examinations ▪ Prostate screenings	Member pays 0% (not subject to deductible)	Member pays 30% after deductible (deductible waived through age 5)
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures)		
▪ Primary Care Physician (PCP)*	$25 copayment	
▪ OB/GYN	$25 copayment	
▪ Specialist Physician	$50 copayment	Member pays 40% after deductible
*Also applies to services rendered at Retail Health Clinics		
Maternity Physician Services		
▪ 1st Prenatal visit	$25 copayment	Member pays 40% after deductible
▪ Global obstetrical care (prenatal, delivery and postpartum services)	Member pays 20% after deductible	Member pays 40% after deductible
Telemedicine Services	$25 PCP copayment or $50 Specialist copayment	Member pays 40% after deductible
Allergy Services		
▪ Office visits, testing and the administration of allergy injections	$25 PCP copayment or $50 Specialist copayment	Member pays 40% after deductible
▪ Allergy injection serum	Member pays 20% after deductible	Member pays 40% after deductible

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Office Surgery (surgery and administration of general anesthesia)	Member pays 20% after deductible	Member pays 40% after deductible
Office Therapy Services ▪ Physical Therapy and Occupational Therapy: 20-visit benefit period maximum combined ▪ Speech Therapy: 20-visit benefit period maximum ▪ Chiropractic Care/Manipulation Therapy: 20-visit benefit period maximum	$25 copayment	Member pays 40% after deductible
Other Therapy Services (chemotherapy, radiation therapy, cardiac rehabilitation [36-visit benefit period maximum] and respiratory/pulmonary therapy)	Member pays 20% after deductible	Member pays 40% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 20% after deductible	Member pays 40% after deductible
Urgent Care Services	$60 copayment	Member pays 40% after deductible
Emergency Room Services ▪ Life-threatening illness or serious accidental injury only ▪ The ER copayment will be waived if admitted to the hospital	$150 copayment; then member pays 20%	$150 copayment; then member pays 20%
Outpatient Facility Services ▪ Surgery facility/hospital charges ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 20% after deductible	Member pays 40% after deductible
Inpatient Facility Services ▪ Daily room, board and general nursing care at semi-private room rate, ICU/CCU charges; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 20% after deductible	Member pays 40% after deductible
Skilled Nursing Facility ▪ 150-day benefit period maximum	Member pays 20% after deductible	Member pays 40% after deductible
Mental Health/Substance Abuse Services (*services must be authorized by calling 1-800-292-2879)		
▪ Inpatient mental health and substance abuse services* (facility and physician fee)	Member pays 20% after deductible	Member pays 40% after deductible
▪ Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)* (facility and physician fee)	Member pays 20% after deductible	Member pays 40% after deductible
▪ Office/Outpatient mental health and substance abuse services (physician fee)	$25 copayment	Member pays 40% after deductible
Home Health Care Services ▪100-visit benefit period maximum	$25 copayment	Member pays 40% after deductible
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% (not subject to deductible)	Member pays 30% after deductible
Durable Medical Equipment (DME)	Member pays 20% after deductible	Member pays 40% after deductible
Ambulance Services (covered when medically necessary)	Member pays 20% after deductible	Member pays 20% after deductible

Prescription Drugs Note: If a member receives a brand name drug that falls on Tier 3 that has a generic equivalent available, the member pays the Tier 1 copay, plus the difference in cost between the brand drug and generic drug. This applies even when physician indicates DAW (dispense as written).	
Retail and Home Delivery maintenance drug coverage is provided at one of four tier levels in accordance with the Formulary Drug List. Members must file a claim form for reimbursement when using an out-of-network pharmacy. Specialty drugs can only be obtained from a Specialty Pharmacy. Refer to last page for Tier definitions	
▪ Retail Drugs – Tier 1 (30 day supply)	$15 copayment
▪ Retail Drugs – Tier 2 (30 day supply)	$35 copayment
▪ Retail Drugs – Tier 3 (30 day supply)	$60 copayment
▪ Retail Drugs – Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	$15 copayment
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	$70 copayment
▪ Home Delivery Maintenance Drugs - Tier 3 (90 day supply)	$180 copayment
▪ Home Delivery Maintenance Drugs – Tier 4 (Specialty Drugs) (90 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period

Your benefit period may be a calendar year or plan year. A calendar year means your benefit period runs from January through December while a plan year runs from the effective date of the plan through a 12-month period.

For a full disclosure of all benefits, exclusions and limitations please refer to your Certificate Booklet.

Prescription Drug Tier Definitions

Tier 1 – These drugs have the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.

Tier 2 – These drugs will have a higher copayment than tier 1 drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

Tier 3 – These drugs will have a higher copayment than tier 2 drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single source brand drugs, or multi-source brands drugs.

Tier 4 – Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier will contain Specialty Drugs.

Pre-Existing Condition Limitation and Credit for Prior Coverage

For in-network services, there is no pre-existing condition limitation. For out-of-network services, benefits are not available during a pre-existing limitation period for services for any illness, injury or condition for which medical advice or treatment was recommended by, or received from, a health care provider within six months preceding the effective date of coverage. The pre-existing limitation period may be reduced or eliminated by the submission of a certificate of prior creditable coverage. The pre-existing limitation period does not apply to newborns, members under age 19, adoptions, placements for adoption or pregnancies.

Summary of Limitations and Exclusions

Your *Certificate Booklet* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Non-emergency use of the emergency room
- Removal/extraction of impacted teeth
- Private duty nursing
- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and radiation for head and neck cancer
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Smoking cessation products

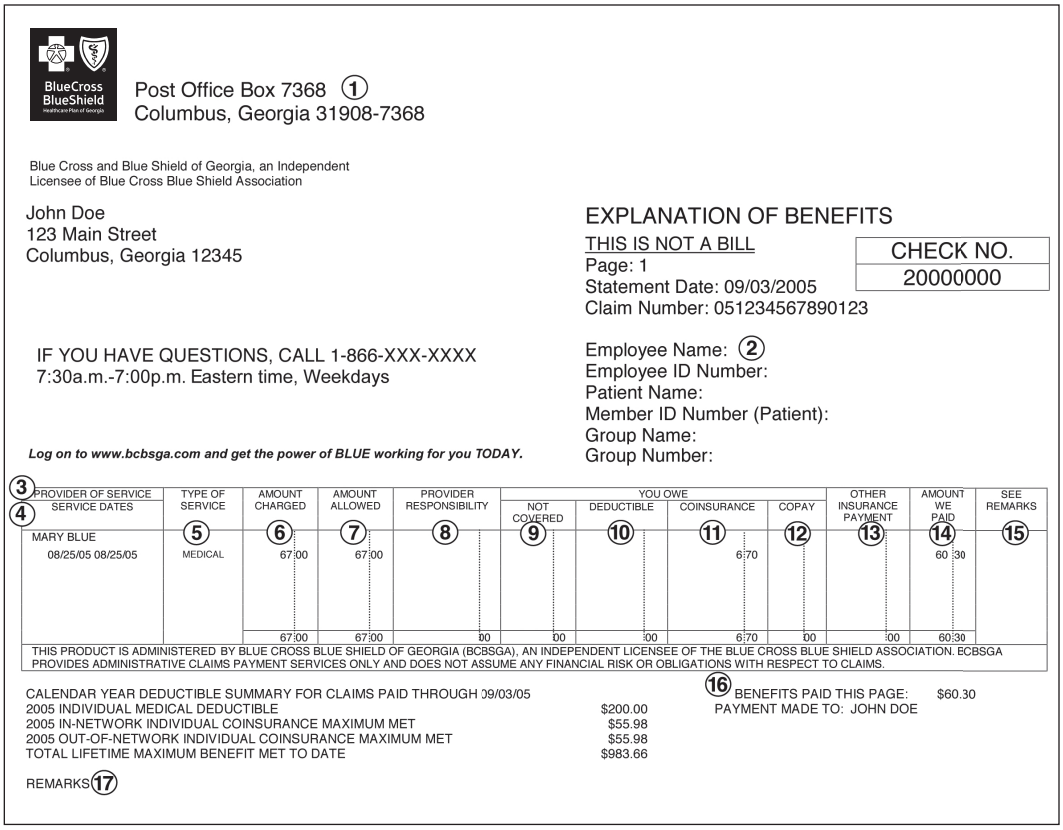
See Certificate Booklet for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your *Certificate Booklet Form# WGAPOS-001, 01012012* (the contract) for a complete explanation of covered services, limitations and exclusions.

Open Access POS Plan Design Number Legend
OAP = Open Access POS
5 = copay and deductible/coinsurance benefit plans
A = Rx option A

The Power of Blue℠

Explanation of benefits



Post Office Box 7368 (1)
Columbus, Georgia 31908-7368

Blue Cross and Blue Shield of Georgia, an Independent Licensee of Blue Cross Blue Shield Association

John Doe
123 Main Street
Columbus, Georgia 12345

EXPLANATION OF BENEFITS
THIS IS NOT A BILL
Page: 1
Statement Date: 09/03/2005
Claim Number: 051234567890123

CHECK NO.
20000000

IF YOU HAVE QUESTIONS, CALL 1-866-XXX-XXXX
7:30a.m.-7:00p.m. Eastern time, Weekdays

Employee Name: (2)
Employee ID Number:
Patient Name:
Member ID Number (Patient):
Group Name:
Group Number:

Log on to www.bcbsga.com and get the power of BLUE working for you TODAY.

(3) PROVIDER OF SERVICE (4) SERVICE DATES	TYPE OF SERVICE	AMOUNT CHARGED	AMOUNT ALLOWED	PROVIDER RESPONSIBILITY	YOU OWE: NOT COVERED	YOU OWE: DEDUCTIBLE	YOU OWE: COINSURANCE	YOU OWE: COPAY	OTHER INSURANCE PAYMENT	AMOUNT WE PAID	SEE REMARKS
		(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
MARY BLUE											
08/25/05 08/25/05	MEDICAL	67.00	67.00				6.70			60.30	
		67.00	67.00	.00	.00	.00	6.70	.00	.00	60.30	

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CALENDAR YEAR DEDUCTIBLE SUMMARY FOR CLAIMS PAID THROUGH 09/03/05

2005 INDIVIDUAL MEDICAL DEDUCTIBLE	$200.00
2005 IN-NETWORK INDIVIDUAL COINSURANCE MAXIMUM MET	$55.98
2005 OUT-OF-NETWORK INDIVIDUAL COINSURANCE MAXIMUM MET	$55.98
TOTAL LIFETIME MAXIMUM BENEFIT MET TO DATE	$983.66

(16) BENEFITS PAID THIS PAGE: $60.30
PAYMENT MADE TO: JOHN DOE

REMARKS (17)

1. *Mailing Address:* Please use this address for any correspondence you send to us.
2. *Employee Information:* This information includes the covered member's name and ID number, patient's name and member ID number, employer or group name, and the employer's group number.
3. *Provider of Service:* An institution, individual or organization that provides a medical service for you.
4. *Service Dates:* Date(s) the patient received care.
5. *Type of Service:* This section indicates the type of care received, such as medical, surgical or laboratory.
6. *Amount Charged:* The amount your provider charged for the service or care you received.
7. *Amount Allowed:* The portion of the amount charged that is allowed for under your contract.
8. *Provider Responsibility:* You are not responsible for these charges.
9. *Not Covered:* Charges that are not covered under your contract and that you are responsible for paying.

Explanation of benefits (continued)

10. *Deductible:* The amount of covered expenses that you must pay before you are eligible for benefits. This includes all deductibles stated in your contract.
11. *Coinsurance:* The portion of covered services that is your responsibility to pay.
12. *Copay:* The fee collected at the time service is rendered by the provider. This fee is a flat dollar amount that is indicated in your contract.
13. *Other Insurance:* The amount of benefit dollars paid toward this claim by another insurance company due to coordination of benefits.
14. *Amount We Paid:* The amount we paid for the service listed on your explanation of benefits.
15. *See Remarks:* A number appears here if an explanation is needed to clarify actions taken on your claim.
16. *Benefits Paid This Page:* The amount paid for all the claims listed.
17. *Remarks:* Numbered remarks referring to the claim. General remarks without a number also may appear here.

-FOR PROVIDER USE ONLY-

EXPLANATION OF HEADINGS:

UCR The difference between the amount charged and the usual, customary and reasonable allowance as defined in the provider agreement.

Pay Adjustment The amount of contracted discount or other fee adjustment as defined in the provider agreement.

Withholds The amount of payment withheld as defined in the provider agreement.

Not Covered Non-covered services for which the provider is liable.

TYPE OF SERVICE (TS)

F	SURGICAL CENTER/AMBULATORY	W	PHYSICAL THERAPY	4	DIAGNOSTIC X-RAY
N	DONOR SERVICES	Y	SECOND OPINION	5	DIAGNOSTIC LAB
P	DME PURCHASE	Z	THIRD OPINION	6	RADIATION THERAPY
R	DME RENTAL	1	MEDICAL CARE	7	ANESTHESIA
T	THERAPY PSYCH	2	SURGERY	8	SURGERY ASSISTANT
U	OCCUPATIONAL THERAPY SERVICE	3	CONSULTATION	9	OTHER MEDICAL

OTHER COVERAGE
Y YES, OTHER INSURANCE IS INDICATED
N NO OTHER COVERAGE INDICATED

PATIENT RESPONSIBILITY
Includes services not covered under the subscriber's contract deductibles and coinsurance.

Your prescription drug plan

Retail pharmacy network

Our network includes more than 56,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

To make sure your pharmacy's in our network, visit **bcbsga.com**.

- Log in and click on "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left-hand column.
- Click on "Find a Pharmacy."

Home Delivery Pharmacy

Home delivery is for people who take medicine on an ongoing basis. Our preferred home delivery pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Getting started with home delivery

Switching is simple. You can order by mail or fax. Your order should arrive within 14 days of the date we receive your order form.

Note about your pharmacy information on the web:

Express Scripts is the company that manages the operations of your drug plan. The first time you're directed to the Express Scripts website, you'll go through a brief registration. The purpose is to set your preferences for communication and privacy. You'll do this only once.

Please do not go directly to the Express Scripts website. The only way to make sure you're viewing your pharmacy information correctly is by logging in to **bcbsga.com** first.

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Your prescription drug plan (continued)

By mail: Visit **bcbsga.com** to get an order form.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "Fill a New Prescription."
- Choose the "Print a Prescription Order Form" link. You can print the form and complete it by hand. Or you can fill out a web-based form and print it.
- Mail your completed form, prescription from your doctor for a 90-day supply, and payment to:

  Home Delivery Pharmacy
  PO Box 66785
  St. Louis, MO 63166-6785

By fax: Have your doctor fax your prescription and plan ID card to **800-600-8105**. It must be faxed directly from your doctor's office. If there is a question about your prescription, the pharmacy will contact your doctor.

Ordering refills

With home delivery, you don't have to worry about running out of medicine. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online.

By phone: Have your prescription label and credit card ready. You can order whenever you like, 24/7. Call **866-281-4654** and select "Automated Refill Order Line" from the menu. Or press zero any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-899-2114**. Follow the prompts to place your order.

By mail: Fill out an order form you received with a previous order. Affix your label or write your refill number in the space provided. Mail the form and your payment to:

Home Delivery Pharmacy
PO Box 66785
St. Louis, MO 63166-6785

Online: Visit **bcbsga.com**.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Choose the drugs you want to refill, and click "Add Refills to Cart."
- Review the order, shipping method, payment, medical information and contact information, and make changes if needed.
- Click "Place My Order."

Your prescription drug plan (continued)

Specialty pharmacy

CuraScript, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. They include (but aren't limited to):

- Asthma
- Bleeding disorders
- Cancer
- Crohn's disease
- Cystic fibrosis
- Growth hormone deficiency
- Hepatitis
- HIV/AIDS
- Iron overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from your treatments.

CuraScript's CareLogic© programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. They also will help you manage the side effects of treatment.

Call 888-773-7376, Monday through Friday, 8 a.m. to 9 p.m., Eastern time, to learn about how CareLogic can help you better manage your health condition.

Ordering specialty drugs

You can place your first order by phone or fax.

By phone: Call **800-870-6419**, Monday through Friday, 8:00 a.m. to 10:00 p.m.; Saturday, 9:00 a.m. to 1:00 p.m., Eastern time. A patient care advocate will help you get started.

By fax: Ask your doctor to fax your prescription and a copy of your plan ID card to **800-824-2642**.

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Your prescription drug plan (continued)

Ordering refills

Online: Visit **bcbsga.com**.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Choose the drugs you want to refill, and click "Add Refills to Cart."
- Review the order, shipping method, payment, medical information and contact information, and make changes if needed.
- Click "Place My Order."

Note: For some drugs, you must call to order a refill.

By phone: Have your member ID number and CuraScript prescription number ready. Call **800-870-6419**, Monday through Friday, 8:00 a.m. to 10:00 p.m.; Saturday, 9:00 a.m. to 1:00 p.m., Eastern time, and select "Place a Refill Order" from the menu. Or press zero any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-221-6915**. Follow the prompts to place your order.

Drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs.

We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the drug list if new drugs come to market, or if new research becomes available. To view the current list, visit **bcbsga.com**. Click on "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the drug list on this page.

If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

Generic drugs

If you're taking a brand-name drug, you may save money by switching to an effective, lower-cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, your drug will work just as well as a brand drug – but usually at a lower cost.

Brand and generic drugs have the same active ingredient, strength and dose. And, generics must meet the same high standards for safety, quality and purity.

Your prescription drug plan (continued)

Why generics cost less

Developing a new drug is expensive. When a company creates a new drug, it gets a patent for up to 20 years. That means only the company that created it can sell it during that time. Once the patent expires, other companies can make copies of the same drug. These companies can avoid the high costs of developing the drug – and that helps lower the price for you.

Talk to your doctor to see if a generic is right for you. Don't switch or stop taking any drugs until you talk to your doctor.

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less
- Rules for use with very specific conditions

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

The drug list also includes this information. To view it, visit **bcbsga.com**. Click on "Customer Care" in the top-right corner. Select your state, then click on "Download Forms." You'll find the drug list on this page.

EXPRESS SCRIPTS®

HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:
1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
   Express Scripts Home Delivery Service
   PO Box 66785
   St. Louis MO 63166-6785

To FAX your prescription:
1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
   - **Class II prescriptions cannot be faxed.**
   - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

E-mail: _____

Allergies: _____

_____

Health Conditions: _____

_____

_____

Over-the-Counter Medications: _____

_____

DOCTOR/PRESCRIBER

DEA: _____

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

PATIENT OPTIONS

☐ I want non-child resistant caps, when available.
☐ I want a copy of my bottle label in large print on a separate sheet of paper.
☐ Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for $21.

If you want to make a payment or update your health conditions, please visit your health plan provider's website.

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Rx

_____ _____ **Date:** __ __ / __ __ / __ __
First Name **Last Name**

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X _____
Doctor/Prescriber Signature – Substitution Permissible

X _____
Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.

Additional Benefits

WELCOME TO YOUR DENTAL PLAN!

This benefit summary outlines the basic components of your plan, providing you with a quick reference of your dental plan benefits. For complete coverage details, please refer to the plan certificate.

Voluntary Dental Plan 7510DV

Dental coverage you can count on
Blue Cross Blue Shield of Georgia Dental Plans allow you to visit any licensed dentist or specialist you want—with costs that are normally lower when you choose to visit a participating provider.

Finding a dentist is easy
To select a dentist by name or location, do one of the following:
- Go to bcbsga.com
- Call Dental Customer Service at 877-330-5973

YOUR DENTAL PLAN AT-A-GLANCE

Annual Benefit Maximum – Calendar Year	**$1,000 per insured person**
Annual Deductible – Calendar Year	**$50 per insured person / up to $150 per family**
Deductible Waived for Preventive Services:	
Participating Providers	**Yes**
Non-Participating Providers	**Yes**
Non-Participating Provider Reimbursement Based On:	**80th Percentile**

DENTAL SERVICES Following are examples of what is/is not covered by your plan:	**PARTICIPATING PROVIDERS** We pay:	NON-PARTICIPATING PROVIDERS We pay:
Preventive Services, for example:		
○ Periodic oral evaluation (0120)	**100%**	100%
○ Prophylaxis (cleaning) Adult (1110)	**100%**	100%
○ Prophylaxis (cleaning) Child (1120)	**100%**	100%
○ Bitewing X-rays – four films (0274)	**100%**	100%
Basic Services, for example:		
All Other X-rays		
○ Intraoral – complete series (0210)	**80%**	80%
Fillings		
○ amalgam, two surfaces (2150)	**80%**	80%
Simple Extractions (7140)	**80%**	80%
Major Services, for example:		
Endodontics		
○ root canal, molar (3330)	**Not covered**	Not covered
Periodontics		
○ scaling and root planing, per quadrant (4341)	**Not covered**	Not covered
Oral Surgery	**Not covered**	Not covered
Prosthodontics		
○ crown, porcelain fused to high noble metal (2750)	**Not covered**	Not covered
○ denture, complete, upper or lower (5110/5120)	**Not covered**	Not covered
Orthodontic Services:	**Not covered**	Not covered
○ Age Limit	**n/a**	n/a
○ Ortho Lifetime Maximum Benefits	**n/a**	n/a
Waiting Periods – Late Entrants & New Hires *(unless takeover provisions apply)*		
Simple Extractions	**6 months**	6 months

This is not a contract. It is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms, and provisions of the dental certificate. In the event of a discrepancy between the information contained in this benefit summary and that in the dental certificate, the dental certificate will prevail.

Participating and Non-Participating Providers
Percentages shown in the benefits chart herein reflect the percentage of the Covered Expense that we will pay.

Participating Providers are dentists who have contracted with us to provide dental care to our members at a negotiated rate. Participating dentists have agreed to accept a negotiated rate as payment in full for covered services. The negotiated rate is usually lower than the participating dentist's normal charge. By choosing a participating dentist, you will be responsible for any applicable deductible and coinsurance amounts, however you will not be responsible for amounts in excess of the negotiated rate for covered services.

Non-Participating Providers are dentists who have not contracted with us and therefore may charge their usual fee for services they provide to you. When you receive services from a non-participating provider, you will be responsible for any applicable deductible and coinsurance amounts, plus any charges in excess of the allowable charge. This means that if the non-participating dentist charges more than the allowable charge, the non-participating dentist may bill you for the difference.

Predetermination of Benefits
Prior review is recommended for any treatment plan that is expected to cost more than $350.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan identification card or call 877-330-5973 to speak in-person with a U.S. based customer service representative during normal business hours. Calling after-hours? We may still be able to assist you with our interactive voice-response system at 877-330-5973.	Refer to the back of your plan identification card for the claims submission address. Other correspondence may be sent to: PO Box 9201 Oxnard, CA 93031

Limitations & Exclusions

Limitations	Exclusions
Limitations — Below is a partial listing of plan limitations. Please see your Certificate of Coverage for a full list. **Diagnostic and Preventive Services** **Oral evaluations** (exam). Limited to two per calendar year. **Prophylaxis** (cleaning). Limited to two per calendar year. **Bitewing x-rays.** Limited to two series per calendar year. **Complete series x-rays** (panoramic or full-mouth). Limited to once in 60 months. **Restorative Services** – ***applicable if these benefits are covered under your plan*** **Fillings.** Limited to once per tooth in a five year period. . **ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES** – ***if Orthodontia is included as a benefit of your plan.*** **Orthodontia.** Limited to one course of treatment per member per lifetime for covered dependent children under age 19.	**Exclusions — Below is a partial listing of non-covered services. Please see your Certificate of Coverage for a full list.** **Crowns.** **Removable Prosthodontics.** **Root Canal Therapy.** **Gingivectomy or Gingivoplasty.** **Periodontal Scaling and Root Planing.** **Oral Surgery.** **Services provided before or after the term of this coverage.** Services received before your effective date or after your coverage ends, unless otherwise specified in the plan certificate. **Orthodontics (unless included as part of your plan benefits).** Orthodontic braces, appliances and all related services. **Services or treatments that are not medically necessary.** **Cosmetic dentistry.** Any services performed for cosmetic purposes (including but not limited to external bleaching, bleaching on non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth). **Separate charges for general anesthesia or I.V. sedation.** **Extraction of wisdom teeth.** Removal of immature erupting third molars and nonpathologic, asymptomatic third molars (wisdom teeth) if the patient is under the age of 16. **Treatment of the joint of the jaw and/or occlusion services.** **Implants –** materials implanted into or on bone or soft tissue and all adjunctive services.

The participating dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Blue Cross Blue Shield of Georgia.

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WELCOME TO BLUE VIEW VISION!
Plan D.10.10
Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

Blue View Vision℠

BlueCross BlueShield of Georgia

Your Blue View Vision network
Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Target® Optical, JCPenney Optical, Sears Optical and Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at (866) 723-0515 with questions about vision benefits or provider locations.

Out-of-network services
Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward services and you pay the rest. (In-network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam Every two years	$10 copay; then covered in full	$30 allowance
Eyeglass frames Every two years you may select any eyeglass frame and receive the following allowance toward the purchase price:	$130 allowance then 20% off remaining balance	$45 allowance
Eyeglass lenses *(Standard)* ***Factory scratch coating included*** ***Polycarbonate lenses included for children under 19 years old.*** Transitions ***lenses included for children under 19 years old.*** Every two years you may receive any one of the following lens options:		
• Standard plastic single vision lenses *(1 pair)*	$10 copay; covered in full	$25 allowance
• Standard plastic bifocal lenses *(1 pair)*	$10 copay; covered in full	$40 allowance
• Standard plastic trifocal lenses *(1 pair)*	$10 copay; covered in full	$55 allowance
Eyeglass lens upgrades When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass copayment applies.	**Member cost for upgrades**	Discounts on lens upgrades are not available out-of-network
Lens Options		
• UV Coating	$15	
• Tint (Solid and Gradient)	$15	
• Standard Polycarbonate	$40	
• Transitions lenses	$75	
• Other Photochromics	$75	
• Progressive Lenses[1]		
◦ Standard	$65	
◦ Premium Tier 1	$91	
◦ Premium Tier 2	$97	
◦ Premium Tier 3	$103	
• Standard Anti-Reflective Coating[2]	$45	
• Premium Tier 1 Anti-Reflective Coating[2]	$57	
• Premium Tier 2 Anti-Reflective Coating[2]	$68	
• Other Add-ons and Services	20% off retail price	
Contact lenses Every two years Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses and receive an allowance toward the cost of a supply of contact lenses. *Your contact lens allowance must be used at the time of initial service.*		
• Elective Conventional Lenses	$130 allowance then 15% off the remaining balance	$105 allowance
• Elective Disposable Lenses	$130 allowance *(no additional discount)*	$105 allowance
• Non-Elective Contact Lenses	Covered in full	$210 allowance

No amount over the allowance may be carried forward to subsequent materials in the same or the following calendar year.

[1] Please ask your provider for his/her recommendation as well as the progressive brands by tier.
[2] Please ask your provider for his/her recommendation as well as the coating brands by tier.

WELCOME TO BLUE VIEW VISION!
Plan D.10.10
Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

VISION CARE SERVICES

Contact lens fitting and follow-up
A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.

	IN-NETWORK Member Cost	OUT-OF NETWORK
• Standard contact fitting*	Fitting and follow up visits up to $55	Discounts not available out-of-network
• Premium contact lens fitting**	10% off retail price	

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts – Savings on additional eyewear and accessories – After you use your initial frame or contact lens allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

BLUE VIEW VISION ADDITIONAL SAVINGS	MEMBER SAVINGS
Additional Pair of Complete Eyeglasses	40% discount off retail*
Contact Lenses - Conventional *(Discount applied to materials only)*	15% off retail price
Eyewear Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.	20% off retail price

*Items purchased separately are discounted 20% off the retail price. Blue View Vision's Additional Savings Program is subject to change without notice.

LASER VISION CORRECTION SURGERY
Glasses or contacts may not be the answer for everyone. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to SpecialOffers at bcbsga.com and select vision care.

USING YOUR BLUE VIEW VISION PLAN
The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

OUT-OF-NETWORK
If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt to the below fax number, email address, or mailing address. When visiting an out-of-network provider, you are responsible for payment of services and/or eyewear materials at the time of service.

To Fax: **866-293-7373**
To Email: oonclaims@eyewearspecialoffers.com
To Mail: **Blue View Vision**
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

EXCLUSIONS & LIMITATIONS
This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from Blue View Vision provider. In addition, benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

Combined Offers. Not combined with any offer, coupon, or in-store advertisement.
Experimental or Investigative. Any experimental or investigative services or materials.
Crime or Nuclear Energy. Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available
Uninsured. Services received before insured person's effective date or after coverage ends.
Excess Amounts. Any amounts in excess of covered vision expense.
Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment.
Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits.
Government Treatment. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free.
Services of Relatives. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage.
Voluntary Payment. Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.
Sunglasses. Sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Hospital Care. Inpatient or outpatient hospital vision care.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames, unless insured person has reached a new benefit period.
Frames: Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.
Disclaimer
This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's Policy, which shall control in the event of a conflict with this overview.

The in-network vision providers referred to in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Blue Cross Blue Shield of Georgia.

Blue View Vision GA Group Full Service (9/08)

Health, Wellness & Anthem Advantages

360° Health® programs

The programs you read about here come with your health plan. There is no extra cost for them.

To learn more about these programs online, log in to bcbsga.com and click on "Health and Wellness".

Take charge of your health and the choices you make

We all have different health needs. Maybe you're fit and want to stay that way. Maybe you're living with a chronic condition like asthma. Or maybe you fall somewhere in between. No matter where you fall, our 360° Health program is here to give you all the help you need to live healthier. From tips and tools you can find online to nurses you can talk to on the phone, 360° Health can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

24/7 NurseLine

Round-the-clock access to health information can really help your peace of mind and your physical well-being. That's why we have Nurse Coaches ready to speak with you about your general health issues any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, safeguard your health and the health of your family.

To reach 24/7 NurseLine, just call the customer service number on your ID card and ask to speak to a 24/7 NurseLine representative.

Future Moms

We know your goal is to have a safe delivery and a healthy baby. That's why we offer Future Moms, a voluntary program to help you take care of your baby before you deliver. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues.
- A helpful book: *Your Pregnancy Week by Week*
- Tips and facts to help you handle any unexpected events
- A questionnaire to see if you're at risk for preterm delivery

360° Health® programs

- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risks

Enroll in Future Moms by calling the customer service number on your ID card. Ask to speak to a Future Moms representative.

ConditionCare

If you or someone you love has an ongoing illness or health problem, let us help you get more out of life. Our ConditionCare nurses help people of all ages take care of the symptoms of asthma and diabetes. And they work closely with adults who have chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease. With ConditionCare you'll get the information you need to help you feel your very best. Our ConditionCare nurses gather information from you and your doctor. Then they create a personalized plan for you.

Information and support are as close as your phone. Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse.

Information You Should Know

Managing your care if you need to go to a hospital or get a specific medical treatment

If you or a family member needs a certain type of medical care (for example: surgery, a treatment done in a doctor's office, physical therapy, etc.), you may want to know more about the following programs and definitions. They may help you better understand how your benefits work and how your health plan manages your care in these types of situations.

Utilization Management

Utilization Management (UM) is a program that is part of your health plan that lets us make sure you're getting the right care at the right time. Our UM program is made up of a team of licensed health care professionals such as nurses and doctors who do medical reviews. The UM review team goes over the information we have received from your doctor or other health care provider to see if a surgery, treatment or other type of care that has been requested is medically needed. The UM review team checks to make sure that the treatment meets specific rules set by your health plan. After reviewing the records and information, the surgery or treatment will be approved (covered) or denied (not covered) and the UM review team will let you and your doctor know as soon as possible.

Medical reviews like this can be done before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before medical care is given)
A prospective review is done before a member goes to the hospital or has some other type of service or treatment.

Here are some types of medical needs members may have that might call for a prospective review:

- To go to (and/or stay at) a hospital
- An outpatient procedure (the member can go home the same day)
- Tests done to try to find the cause of an illness such as MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) scans
- A certain type of outpatient therapy such as physical therapy or emotional health counseling
- "Durable medical equipment" (DME) which means wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)
A concurrent review is done at the time the member is in the hospital or is released and needs more care related to the hospital stay. This could mean services or treatment done in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment (see above), staying in a nursing home, getting emotional health care and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

The retrospective or post-service review (done after medical care is given)
A retrospective review is done when a member has already had surgery or another type of medical care. When the UM review team becomes aware of the treatment, they will look at the member's medical information that the doctor or provider had at the time the medical care was given. They can then see if the treatment was medically needed.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions, and help you better understand your health benefits.

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Your rights and responsibilities as a Blue Cross and Blue Shield of Georgia member

As a Blue Cross and Blue Shield of Georgia (BCBSGA) member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.

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Your rights and responsibilities as a Blue Cross and Blue Shield of Georgia member (continued)

- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

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Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Blue Cross and Blue Shield of Georgia benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your

dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Important legal information you should take time to read (continued)

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Important legal information you should take time to read

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

This Notice is provided by the following company: **Blue Cross and Blue Shield of Georgia**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

Health care reform and your plan

You've most likely heard a lot of people talk about health care reform lately. But you may have questions about what it all means for you and your family. Here's a quick review of what the new law may mean to your group health plan. Keep in mind that other company plans may have different rules. If you have questions about your specific benefits, call the customer service number on your member ID card or ask your group benefits administrator for a number to call.

What's changed: When you join, you'll have a chance to add young adult children to your plan.

The federal health care reform law lets children (also called dependents) stay on their parent's or guardian's health plan until the end of the month when they turn 26 years old. In some states, they can stay on the plan even longer.

Children can be on your plan even if they are not:

- Financially dependent on you for support
- Claimed as dependents on your tax return
- Residents of your household
- Enrolled as students or unmarried

If you have children younger than 26 who aren't on your plan now and your company offers coverage for children, you can add them to your plan during your next open enrollment. If your plan already covers children up to age 26, you don't have to do anything. They'll stay on your plan automatically.

What's changed: Children under 19 can get coverage even if they have health problems.

The law says group health plans can't deny coverage to children under 19 if they have pre-existing conditions (health problems). Here's how a website run by the federal government, called healthcare.gov, defines a pre-existing condition: a pre-existing condition is "a condition, disability or illness (either physical or mental) that you have before you enrolled in a health plan."

Very few group health plans deny coverage because of pre-existing conditions. But some plans still have waiting periods. A waiting period means that a child under 19 has to wait a certain amount of time before he or she can get covered for certain services.

17076MUMENMUB 5/11

Health care reform and your plan (continued)

What's changed: No more lifetime maximum dollar limits.

In the past, health plans could have a "lifetime maximum" – a dollar limit on what the plan will pay for health care services over your lifetime. If your plan had a lifetime maximum, it's gone now. But other limits may still apply. For example, you may have limits on certain services that aren't considered "essential health benefits." Also, you may have limits on how many times you can use a benefit during the year. Check your Summary of Benefits to see if this applies to you.

What's new: You may have more choices in which doctors you can use.

This part of the law applies to you only if your plan says that you must choose a primary care provider (PCP) and get referrals from your PCP to see a specialist.

- If you have this type of plan (like an HMO), you can choose any PCP as your primary care doctor but the doctor has to be in our network, has to be accepting new patients and will accept you or your family members as patients.
- If your plan covers children, you may choose a pediatrician as their PCP.
- Also, you don't need a referral from your PCP or prior approval from your health care plan to see a gynecologist or obstetrician, as long as those doctors are in our network.

What's next? We'll keep you in the loop.

Things are going to keep on changing for a while. This notice only includes changes that may affect you within the next year. As things continue to change, we'll keep you up to date to make sure you get all the benefits that can help you and your family get and stay as healthy as possible.

17076MUMENMUB 5/11

If you have a medical condition before joining our plan you may have to wait for coverage

Your Blue Cross and Blue Shield of Georgia (BCBSGA) health plan has a pre-existing condition exclusion. This means that if you have a medical condition that was diagnosed before coming to our plan, you might have to wait 12 months before your plan will pay for health care services related to that issue.

What are examples of pre-existing conditions?

- Health issues like asthma, heart disease, diabetes, etc.
- Health issues that a doctor told you that you have within the last six months.
- Health issues you have had health care treatment for in the last six months.

Waiting periods

There are two types of waiting periods:

- **If you didn't have health coverage before** coming to BCBSGA you may have to wait the whole 12 months.
- **If you did have health coverage before** coming to BCBSGA you may not have to wait. It depends on what type of coverage you had. If it has been less than 63 days since you had health coverage before starting with BCBSGA, you may be able to cut down your 12-month waiting period by the number of days you had coverage.

Note: If your employer requires a waiting period, you cannot have had a doctor diagnose a pre-existing condition on or before the day your waiting period begins.

So for example – if your waiting period on your new job begins on October 1 – any condition that's been diagnosed or treated for the six months up until September 30 would be considered a pre-existing condition. So you would have to be in a waiting period for coverage.

Other exceptions include:

- Being pregnant – you will not have to wait if you are pregnant
- If you are under age 19
- A child or children who are signed up for coverage within 31 days after birth, adoption or placement for adoption

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If you have a medical condition before joining our plan you may have to wait for coverage (continued)

If you had recent health coverage, follow these steps to show proof of that coverage.

- Check your last ID card from the company you had health coverage with to get the phone number or address.
- If your coverage was through your last job and you don't know how to reach the insurance company that covered you before, call the Human Resources phone number where you used to work.
- Check if you have a health plan booklet or other information about your coverage from that company. You may be able to find a phone number there. You can always call BCBSGA for help on how to do this.
- Once you have the contact information for the company that you had health coverage with, contact them.
- Ask them how to get a "certificate of creditable coverage" or other proof that you had health coverage with them.
- Once you get your "certificate of creditable coverage" from them, send it to our address on the back of your new BCBSGA ID card.

Need help?

We're here for you. Call us at the phone number on the back of your BCBSGA ID card if you have questions about coverage for pre-existing conditions. If you don't have your ID card yet, contact your human resources department for the phone number.

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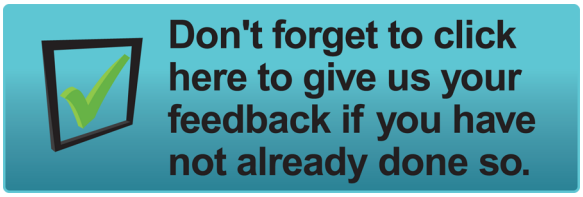
Don't forget to click here to give us your feedback if you have not already done so.

Once you're a member, it's easy to get answers to any questions about your plan.

Just call the number on the back of your member identification (ID) card after you get it.

BlueCross BlueShield Healthcare Plan of Georgia

BlueCross BlueShield of Georgia