BlueCross BlueShield of Georgia

GEORGIA **Tonik effective 9-23-2010** $1,500 – Calculated Risk Taker

Summary of Benefits	In-Network	Out-of-Network
All In-Network care must be received from a Preferred Provider		
Lifetime Medical Maximum Benefit All In-Network and Out-of-Network Benefits Combined	Unlimited	
Calendar Year Deductible In-Network and Out-of-Network Combined	$1,500	
Percentage Payable (Unless Otherwise Specified)		
Plan Pays	100%	70%
Member Pays	0%	30%
Percentage Payable after the Out-of-Pocket Maximum is met	100%	100%
Unless otherwise specified, no benefits are payable until the Calendar Year Deductible is satisfied.		
Out-of-Pocket Maximum Per Calendar Year (For out-of-network services, this amount is in addition to the Deductible and Copayment) In-Network and Out-of-Network Amounts Combined	$1,500	$10,000
Inpatient Hospital Services Room and Board, Hospital services and supplies (Pre-certification Required for all inpatient stays)	100%	Plan pays $650 per day toward Eligible Charges
Outpatient Hospital Services / Ambulatory Surgical Center (Outpatient Pre-certification required for specified procedures)	100%	Plan pays $380 per day toward Eligible Charges
Professional Services As outlined in the Benefits Section of this Contract	100%	70% of Eligible Charges, subject to balance billing
Accidental Injury or Medical Emergency Emergency Room Copayment *Not subject to the Calendar Year Deductible* Initial services rendered for the onset of symptoms for a life-threatening medical condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. The emergency room Copayment is waived if admitted to the Hospital.	$100	$100 Plus all charges in excess of Eligible Charges

Summary of Benefits	In-Network	Out-of-Network
Office Visits *Applicable copayments and coinsurance will continue to be required after the Deductible and/or Out-of-Pocket maximum is met.*	$40 Copayment	70% of Eligible Charges, subject to balance billing
Professional Ambulance Service – Covered when Medically Necessary and rendered by a state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.		
Land Ambulance	100%	100%
Air Ambulance	100%	100%
Mental Health Care and Substance Abuse Treatment – Hospital Services		
Maximum payment per day toward Eligible Charges	$100	$100
Calendar Year maximum benefit (In- and Out-of-Network Combined)	12 Days	12 Days
Mental Health Care and Substance Abuse Treatment – In or Outpatient Professional Charges		
Per visit maximum toward Eligible Charges	$30	$30
Calendar Year visit maximum (In- and Out-of-Network Combined)	12	12
Vision Services Maximum benefit per Calendar Year (not subject to the Calendar Year Deductible)	$50	$50
Dental Injury Services of a Physician or dentist treating an accidental injury to natural teeth or structure occurring while a Member is covered by this Contract and when services are performed within 180 days of the date of accident.	100%	Plan pays 70% of Eligible Charges, subject to balance billing.
Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers		
Plan pays	100%	$25 per visit of Eligible Charges
Visit Maximum per Calendar Year, In-Network and Out-of-Network combined	12	12
Visit Maximum for treatment of the following diagnoses, In-Network and Out-of-Network combined: • Post neurological surgery • Orthopedic surgery • Cerebral vascular accident (stroke)	24	24

Summary of Benefits	In-Network	Out-of-Network
• Third degree burns • Head trauma • Spinal Cord Injury		
Speech Therapy Maximum visit per Calendar Year following surgery, injury or non-congenital organic disease	100% 50	70% of Eligible Charges, subject to balance billing. 50
TMJ	100%	70% of Eligible Charges, subject to balance billing.
Smoking Cessation Lifetime Maximum benefit for any smoking cessation program	$50	$50
Home Health Care Services Visit Maximum per Calendar Year, In-Network and Out-of-Network combined	100% 60	$75 payable per visit toward Eligible Charges 60
Skilled Nursing Facility Care Visit Maximum per Calendar Year, In-Network and Out-of-Network combined	100% 100	$150 payable per day toward Eligible Charges 100
Telemedicine / Teleradiology Services	100%	70% of Eligible Charges, subject to balance billing
Foreign Country Provider Covered services limited to initial treatment of a Medical Emergency only. Must obtain, at your expense, an English language translation of foreign country claims and medical records.	Member pays all charges in excess of Eligible Charges	
Durable Medical Equipment and Supplies	100%	70% of Eligible Charges, subject to balance billing
Preventive Health Care **Preventive Services for Children Age 5 and Under – Not Subject to the Calendar Deductible** • Periodic Health Assessments • Development assessment of the child • Age appropriate immunizations • Laboratory testing	100% Not subject to the Deductible	70% of Eligible Charges, subject to Balance Billing.

Summary of Benefits	In-Network	Out-of-Network
Preventive Services for Children Over Age 5 and Adults Services include, but are not limited to: • Periodic Health Assessments • Immunizations • Flu Injections **Preventive Services for Women** • Annual Gynecological Exam • Mammography • Pap Smear • Chlamydia Screening • Ovarian Surveillance • Colorectal Screening • Related Office Visit **Preventive Services for Men** • Prostate Screening • Colorectal Screening • Related Office Visit	100% not subject to the Deductible 100% Not subject to the Deductible	Plan pays 70% of Eligible Charges per office visit, subject to balance billing, not subject to the Deductible Services without an Office Visit are payable at 70% of Eligible Charges after the Calendar Year Deductible is met (subject to balance billing).
Infusion Services	100%	Plan pays $50 per day toward Eligible Expenses for Administration and Professional Services Subscriber pays all charges in excess of the Average Wholesale Price (AWP) of the Drug. $500 per day Combined maximum payable for professional and drugs combined
Contraception Oral contraceptive generic drugs prescribed for birth control and FDA approved prescription devices are covered.	$10 copayment	$10 copayment

Summary of Benefits	In-Network	Out-of-Network
Generic Prescription Drugs	Lesser of cost or $10 copayment	Lesser of cost or $10 copayment
Brand Name Drugs – $2,000 Brand Prescription Drug Deductible per Calendar Year applies in addition to the Medical Calendar Year Deductible.		
Brand Name Preferred Drug	$30 Copayment	$30 Copayment
Brand Name Non-Preferred Drug	$50 Copayment	$50 Copayment
Self-Administered Injectable Drugs (except insulin)	Subscriber pays 30% of the Negotiated Fee	Subscriber pays 30% of the Negotiated Fee
Mail Order Pharmacy		
Generic	$10 Copayment for each 30-day supply $20 Copayment for each 60-day supply	$10 Copayment for each 30-day supply $20 Copayment for each 60-day supply
Brand Name Drugs Brand Name Preferred Drug	$30 Copayment for each 30-day supply $60 Copayment for each 60-day supply	$30 Copayment for each 30-day supply $60 Copayment for each 60-day supply
Brand Name Non-Preferred Drug	$50 Copayment for each 30-day supply $100 Copayment for each 60-day supply	$50 Copayment for each 30-day supply $100 Copayment for each 60-day supply
Self-Administered Injectable Drugs (except insulin)	Subscriber pays 30% of the Negotiated Fee	Subscriber pays 30% of the Negotiated Fee
A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a Prescription Drug requires pre-authorization, please call Customer Service.		
If a non-participating pharmacy is used, the Subscriber must file a claim for reimbursement. The Member may be responsible for the difference between the BCBSGA negotiated rate and the pharmacy's actual charge.		

Exclusions and Limitations

Benefits are not provided for:

1. No maternity benefits are payable under this contract.
2. Care, supplies or equipment not Medically Necessary, as determined by BCBSGA, for the treatment of an Injury or illness.
3. Any item, service, supply or care not specifically listed as a Covered Service in this Contract.
4. Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends. (Such a requirement shall not prejudice an existing claim.) Such services and supplies shall include, but not be limited to, Inpatient Hospital Admissions which begin before a Member's Effective Date.
5. Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
6. Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
7. Any portion of a provider's fee or charge which is ordinarily due from a Member but which has been waived. If a provider routinely waives (does not require the Member to pay) a Deductible or Out-of-Pocket amount, BCBSGA will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
8. Care for any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.
9. Any disease or injury resulting from a war, declared or not, or any military duty, or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities as required by law.
10. Care given by a medical department or clinic run by your employer.
11. Admission or continued Hospital or skilled nursing facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
12. Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
13. Preventative care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
14. Daily room charges while the Contract is paying for an intensive care, cardiac care, or other special care unit.
15. Vision care services and supplies, including but not limited to eyeglasses, contact lenses, hearing aids, hearing devices and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service.
16. Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Contract.
17. The following items related to Durable Medical Equipment:
    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Arch supports, orthopedic or corrective shoes;
    - Heating pads, hot water bottles, home enema equipment or rubber gloves;
    - Sterile water;
    - Deluxe equipment, such as motor driven chairs or beds, when standard equipment is adequate;
    - Rental or purchase of equipment if you are in a facility which provides such equipment;
    - Electric stair chairs or elevator chairs;
    - Physical fitness, exercise, or ultraviolet/tanning equipment;
    - Residential structural modification to facilitate the use of equipment;
    - Other items of equipment which BCBSGA feels do not meet the listed criteria.
18. The following items related to prosthetic devices: corrective shoes; dentures, replacing teeth or structures directly supporting teeth, except to correct traumatic injuries, electrical or magnetic

continence aids, either anal or urethral; hearing aids or hearing devices; implants for cosmetic purpose except for reconstruction following mastectomy.

19. Custodial care, domiciliary care rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.
20. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
21. Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
22. Care, supplies or equipment not Medically Necessary for the treatment of Injury or illness. Non-covered supplies are inclusive of but not limited to: band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business, and adjustments made to vehicles.
23. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regiments or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary be BCBSGA, are not covered.
    - This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions including but not limited to, cleft lip and cleft palate.
    - The following criteria must be met to qualify for breast reduction surgery: The affected area must be more than 250 grams over the normative average.
    - This exclusion does not apply to Breast Reconstruction Surgery. Please see the "Benefits" section of this Contract.
24. Complications of Non-Covered procedures are not covered.
25. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties, dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this Contract.
26. Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care providers as listed in this Contract.
27. Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, surgical care, medical care or Prescription Drugs, or dietary control related to covered nutritional counseling. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Services of Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, surgical or psychiatric care or counseling. Weight loss programs, nutritional supplements, or psychiatric care or counseling. Weight loss programs nutritional supplements, appetite suppressants, and supplies of a similar nature. Procedures including but not limited to liposuction, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, and wiring of the jaw.

28. Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).
29. Transportation provided by other than a state licensed Professional Ambulance Service, and ambulance service other than in a Medical Emergency.
30. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
31. Advice or consultation given by any form of telecommunication.
32. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in BCBSGA's judgment Experimental or Investigational for the diagnosis for which the Member being treated. An Experimental or Investigation service is not made eligible for coverage by thee fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service prescribed as the most likely to prolong life.
33. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
34. Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.
35. Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
36. Services for outpatient therapy or rehabilitation other than those specifically listed in this Contract. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne, and carbon dioxide.
37. Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism.
38. Treatment where payment is made by any local, state or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
39. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Member has enrolled in Medicare Part B.
40. Expenses in excess of the Usual, Customary, and Reasonable (UCR) Fees (as determined by BCBSGA).
41. Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reversal of sterilization, or combination thereof.
42. Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
43. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rental, homemaker services, travel expenses, and take-home supplies.
44. Inpatient Hospital care for mental health conditions when the stay is:
    - determined to be court-ordered, custodial, or solely for the purpose of environment control;
    - rendered in a home, halfway house, school or domiciliary institution;
    - associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related to marital, social, cultural or work situations.
    - incurred through participation in day/night and/or partial hospitalization programs.
45. Outpatient care for Mental Health Disorders or substance abuse treatment.
46. Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delays, including but not limited to services for conditions related to autistic disease of

childhood (except to the same extent that we provide for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, Developmental Delay, behavioral problems, and mental retardation. Neither speech, physical nor occupational therapy is covered for Developmental Delay. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.

47. Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Member is medically stable and does not require Skilled Nursing Convalescent Care or the constant availability of a Physician or:
    - the treatment is for maintenance therapy; or
    - the Member has no restorative potential; or
    - the treatment is for congenital learning or neurological disability/disorder; or
    - the treatment is for communication training, educational training or vocational training.
48. Injuries received while committing a crime.
49. Biomicroscopy, field charting or aniseikonic investigation.
50. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
51. Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.
52. Non-emergency treatment of chronic illnesses received outside the United States performed without pre-certification.
53. Any drug or other item which does not require a prescription.
54. Preventive care except as specified in this Contract.
55. The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    - Surgical or medical care related to animal organ transplants, animal tissue transplants (except for porcine heart valves), artificial organ transplants or mechanical organ transplants;
    - Transportation, travel or lodging expenses for non-donor family members;
    - Donation related services or supplies, including search, associated with organ acquisition and procurement;
    - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
    - Any transplant not specifically listed as covered.
56. Acupuncture and acupuncture therapy.
57. Private room, except as specified as specified as Covered Services.
58. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
59. Court-ordered services, or those required by court order as condition of parole or probation.
60. Hypnotherapy.
61. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
62. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
63. Specific medical reports, including those not directly related to treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
64. Thermograms and thermography.
65. Elective abortion.
66. Telehealth consultations will not be reimbursable for the use of audio only telephone, facsimile machine or electronic mail.
67. Sclerotherapy of extremity veins.

The following are Drug Related Non-Covered Services under this Contract:

a. Non-Legend vitamins (those available over the counter without a prescription).
b. Smoking Cessation products (including the use of Wellbutrin SR for this purpose).
c. Over the counter items.
d. Rogaine.
e. Appetite Suppressants (Anorexiants).
f. Weight Loss Products.
g. Diet supplements.
h. Syringes (for use other than insulin).
i. Non-contraceptive injectables (except with pre-certification).
j. The administration or injection of any Prescription Drug or any drugs or medicines.
k. Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued.
l. Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year form the date of the prescription order.
m. Prescription drugs for which there is no charge.
n. Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use.
o. Prescription Drugs for use as an Inpatient or Outpatient of a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients.
p. Charges for delivery of any Prescription Drugs.
q. Drugs and medicines which do not require a prescription order and which are not Prescription Drugs, except insulin.
r. Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs.
s. Prescription Drugs which are not Medically Necessary or which BCBSGA determines are not consistent with the diagnosis.
t. Prescription Drugs which BCBSGA determines are not provided in accordance with accepted professional medical standards in the United States.
u. Any services or supplies which are not specifically listed as covered under this Contract.
v. Prescription Drugs which are Experimental or Investigational in nature as explained in the “Limitations and Exclusions” section.
w. Vaccines delivered by nasal spray or mist.
x. Prescription medicine for nail fungus except for immunocompromised or diabetic patients.

Rights and Obligations

Refund Upon Examination

You have 30 days to read this Contract. If you change your mind and decide you do not want this Contract, you may return it, along with a written request for cancellation within 30 days and any Premiums which you have paid will be returned to you. At that time, you will have no further obligation. This Contract explains the benefits payable. Your only obligation is to pay the Premiums on time. Remember, if you decide you do not want the Contract, we will not pay for any claims you may have during the 30-day period.

Blue Cross and Blue Shield of Georgia (called "BCBSGA" in this Contract) agrees to provide coverage for you. Your coverage is based on the information on your Application for Coverage and on your payment of Premiums to BCBSGA. The amount of money paid on your claims is based on the terms of this Contract.

The Effective Date of this Contract is the date assigned by BCBSGA. After your first payment to BCBSGA (called "Premiums"), the Contract shall be in force until your next payment is due. All payments have a 30-day grace period which is explained in more detail below and also in another section called "General Provisions". Please note, however, that you are not covered until BCBSGA receives your first payment and you are approved for coverage. All payments after the first one must be paid **on or before** the date they are due (BCBSGA calls this date the "**due date**").

For an Individual Coverage Contract (just you and no one else), payment is based on your place of residence, gender and age at the time you apply.

The amount of your payment will be changed automatically based on your area and age-gender bracket. You will be notified 60 days before any change is made.

Except for your first payment, you have a 30-day grace period beyond the due date to pay. Your Contract remains in effect during this 30 days. If you do not make a payment within this 30-day grace period, BCBSGA has the right to refuse to accept your payment and automatically cancel your Contract.

BCBSGA has the right to amend this Contract at any time by giving you written notice of the amendment at least 90 days before the amendment takes effect. You must agree to the change in writing. However, this requirement of notice shall not apply to amendments which provide coverage mandated by the laws of the State of Georgia.

General Provisions

Pre-existing Conditions

1. For a covered person age 19 and older, we do not cover services received during the first 12 months after your Effective Date for pre-existing conditions. A pre-existing exclusion may apply up to twelve (12) months under this contract after the policy start date. If you have been covered by eligible health insurance before this policy, the 12-month waiting period may not apply or the waiting period may be shorter than the entire twelve (12) months. Coverage shall not be available for any illness, injury or other condition for which: medical advice, diagnosis, care or treatment was recommended or received within the previous 12 months preceding the effective date of coverage.
2. Applicants must meet medical underwriting requirements in order to obtain coverage. Certain medical conditions may be excluded from the Contract for specific time periods as determined by medical underwriting.

Excess Coverage Provision

This coverage pays for Eligible Charges after any group health plan has paid. In no case shall the total payment of this health care coverage and other coverage exceed 100% of the Eligible Charges. Eligible Charges which are reimbursed by any group health care plan are not covered by this Contract.

Type of Coverage

The type of coverage available to you are Individual (One-Person).

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