Human Resources Department

MISCELLANEOUS BENEFITS SUMMARY

NOTE: All new hires will be required to attend a **mandatory** Employee Orientation Program, **no exceptions**. Orientation is scheduled based on a minimum of five (5) attendees present each month. In the event there are fewer than fire (5) attendees, orientation will be held the following month. Representatives from the Human Resources Department and other representatives who enroll or administer other employee benefits will discuss City Benefits in detail during Employee Orientation.

If you have any questions regarding the attachments or any other matters concerning your employment with the City of Rome, please contact Human Resources.

607 Broad Street • PO Box 1433 • Rome, Georgia 30162-1433
phone: 706/236-4450 • *fax:* 706/236-4465
www.romega.us

City of Rome Benefits Summary

Group Health - BCBS

	(80% - 20%)
Eligibility	Full Time Only (30 Hours)
% Contributory	City / Employee Single 80% / 20% Employee + Child/Children 75% / 25% Employee + Spouse 75% / 25% Family 75% / 25%
Open Enrollment Period	November of each calendar year
Probationary Period	60 days of employment starting with the 1st day of the following month
Dependents Eligible	- Spouse - Children 26 and under

**Temporary Employees hired to full time status are enrolled the 1st day of the month following the date of hire with the City.*

Group Life – Mutual of Omaha

Who Pays?	How Much?	Face Value
The City of Rome	100% of the employee and dependent premium	One times an employee's annual salary up to a maximum of $50,000; $10,000 for spouse and $10,000 for dependent.

Retirement

Type	Employees Eligible	Description	Waiting Period to Participate	Who Pays? How Much?
Defined Benefit (Pension) GMEBS	All employees working 20 hours or more	Secure Investments	None	The City -100% Vesting Period: 10 years **Retiree must be enrolled in Health Insurance at least 24 months prior to retirement date in order to be eligible for the years of service premium discount.*
457(b) Deferred Compensation Voluntary options MetLife	Available to all employees	Mutual Funds (Stock Market) – Invested in employee's choices	None	The Employee-100% As much or as little as you decide up to the limit set annually by the IRS. The limit for 2015 is $18,000 for those under 55.
401(a) Defined Contribution Voluntary option but based on participation in 457(b) accounts noted above MetLife	Available to all employees	Mutual Funds (Stock Market) – Invested in employee's choices	None	The City-100% Up to 1.25% of your salary match: employee must contribute money to 457(b) in order to receive this match. Vesting Period: 5 years
Public Safety Annuity Plan Voluntary POAB – Police GFPF - Fire	Available only to certified public safety officers (police officers, correctional officers, and firefighters and administrative staff of the fire department)	Provides supplemental retirement income		Both The City contributes $10 per month toward the employees monthly contribution cost. Vesting Period: 15 years

Revised 1/7/2015

Other Benefits that will be covered at New Employee Orientation

Voluntary Dental

Eligibility	Full Time Only (30 Hours)
Cost	Employee pays 100% of premium
Provider	MetLife

Voluntary Long Term Disability (LTD)

Eligibility	Full Time Only (30 Hours)
Cost	City pays 25% of premium Employee pays 75% of premium
Provider	Mutual of Omaha

Voluntary Short Term Disability (STD)

Eligibility	Full Time Only (30 Hours)
Cost	Employee pays 100% of premium
Provider	Mutual of Omaha

Voluntary Term Life

Eligibility	Full Time Only (30 Hours)
Cost	Employee pays 100% of premium
Face Value	Up to $150,000 guaranteed
Provider	Mutual of Omaha

Voluntary Cancer

Eligibility	Full Time Only (30 Hours)
Cost	Employee pays 100% of premium
Provider	Allstate

Voluntary Vision

Eligibility	Full Time Only (30 Hours)
Cost	Employee pays 100% of premium
Provider	Superior Vision

Voluntary Accident

Eligibility	Full Time Only (30 Hours)
Cost	Employee pays 100% of premium
Provider	Allstate

Direct Deposit

The City of Rome processes all payroll checks automatically through Direct Deposit. Pay checks are deposited to any financial institution selected by the employee, as long as, the employee and/or financial institution provides an account number and a routing number. All City of Rome employees must establish a checking or savings account prior to their date of hire; failure to do so may delay the date of hire.

Continuing Education

The City of Rome believes strongly in the benefits of education. In an effort to provide incentive and assistance toward continuing education, educational reimbursement is available to career service employees to reimburse a portion of pre-approved expenses for educational courses which directly relates to the employee's present job or a reasonably attainable promotional objective. Reimbursement will be limited to actual out-of-pocket expenses based on a letter grade (A=100%; B=75%; C=50%; Below C=0%). Any course that is provided on a pass/fail basis under this program will be eligible for 75% tuition reimbursement for successful completion of the course. Maximum reimbursement for a single fiscal year is $3,000 for an Associate's degree, $4, 000 for a Bachelor's degree and $5,000 for a Master's degree.

Adoption Assistance

The Adoption Assistance benefit is designed to provide reimbursement of adoption expenses to assist families adopting a child. The City of Rome will reimburse up to a maximum of $2,500 per child for full-time regular employees and up to a maximum of $1,250 (1/2 FT benefit) per child for part-time regular employees. To be eligible for reimbursement, expenses must have been incurred on or after April 25, 2006.

Note: The above noted descriptions of employee benefits are intended for general summary **only**. For eligibility and complete details, please refer to appropriate sections of the City's Personnel Policy, as well as, to appropriate policy statements, departmental standard operating procedures, local resolutions and ordinances, state statutes, federal laws and codes, and applicable insurance policy plan documents.

Human Resources Department

BENEFIT INFORMATION – GROUP LIFE INSURANCE

Current Life Insurance Provider: Mutual of Omaha (1-1-12)

The City currently offers life insurance at no cost to employees, retirees and their eligible dependents. In order to be eligible for this benefit you must meet one of the following criteria:

A. Be an active employee who is regularly working 30 hours each week.
B. Be an active employee at the time of retirement from the City.
C. Be an eligible dependent of an active employee/retiree.
D. Be an eligible child up to the age of 21; coverage can be extended to age 25 if the child is actively enrolled in college or a technical college as a fulltime (minimum of 12 hours per quarter/semester) student.

Death benefits are paid at one-time an employee's annual base salary rounded to the next higher multiple of $1,000, if not already a multiple of $1,000, up to a maximum amount of life insurance benefit of $50,000. Active employees are also covered for Accidental Death and Dismemberment. As an active employee, spousal benefit will be $10,000 up to age 70 and any eligible dependent child will be covered for $10,000 (see D above). Once an employee retires their spouse life insurance coverage will remain at $10,000.

The following is a breakdown of life insurance benefits based on age which applies to both active and retired status employees:

Age Group	Coverage Amount	Percentage Paid
Ages 18 – 64	Annual Base Salary up to $50,000 Maximum	100%
Ages 65 – 69	Annual Base Salary up to $50,000 Maximum	65%
Age 70+	Annual Base Salary up to $50,000 Maximum	50%

If you have any questions about this or any other benefit offered by the City, please feel free to contact the Human Resources Department.

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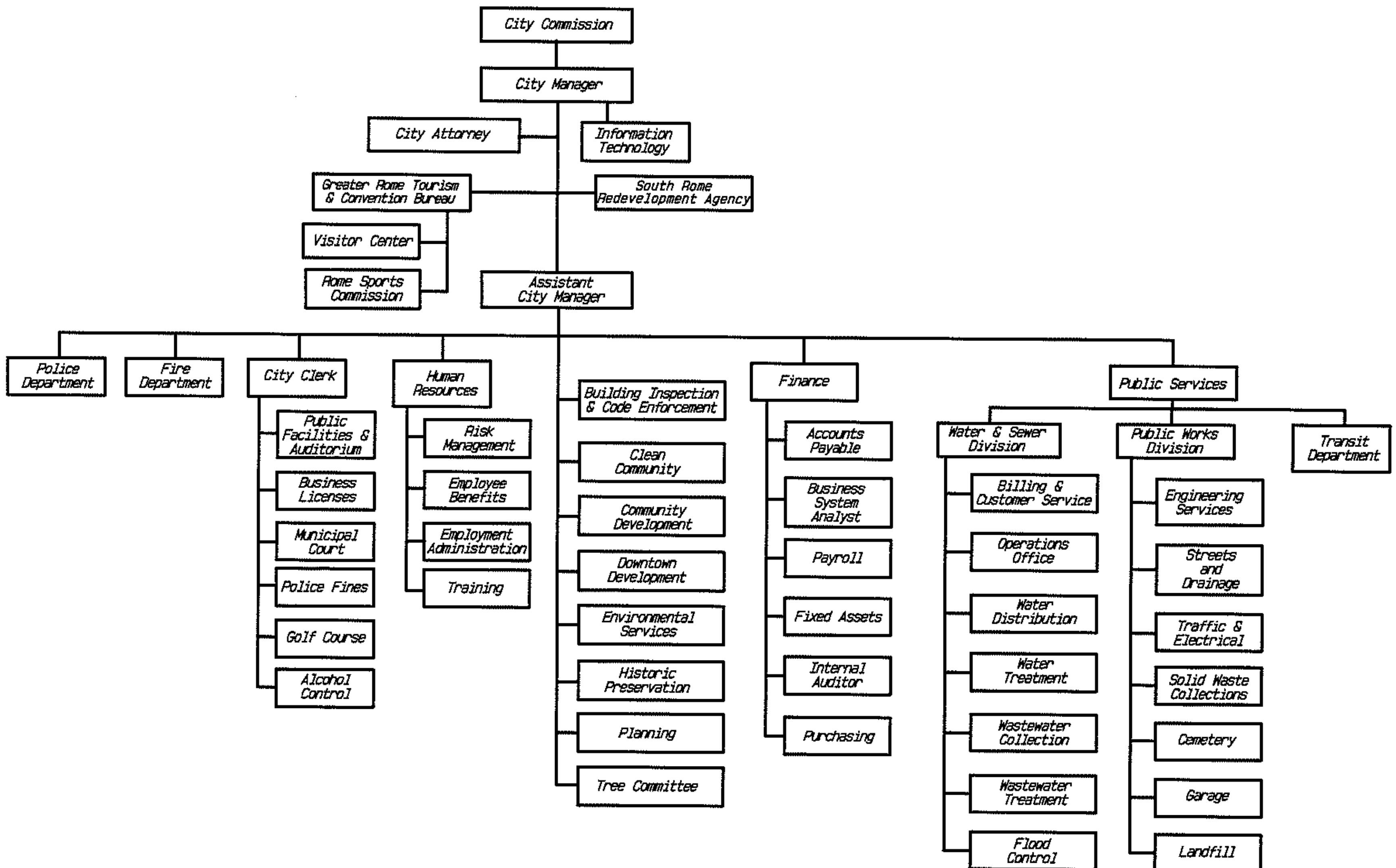
City of Rome, Georgia
Organization Chart



6-02-15

Human Resources Department

2015 HOLIDAY/ANNUAL EVENTS SCHEDULE

The following days are designated as official holidays for City employees. All Administrative Offices will be closed in observance of these holidays as follows:

New Year' Day	Thursday, January 1, 2015
Martin Luther King Day	Monday, January 19
Good Friday	Friday, April 03
Memorial Day	Monday, May 25
July 4th	Friday, July 3
Labor Day	Monday, September 7
Thanksgiving Day	Thursday, November 26
Christmas Eve (1/2 day)	Thursday, December 24
Christmas Day	Friday, December 25
New Year's Day/2016	Friday, January 1, 2016

Other holidays or closings may be declared by the Commission at their discretion. *Note: From year to year, the City may close* *__administrative operations__* *at City Hall and the Carnegie Building (i.e. Friday after Thanksgiving and the ½ day Christmas Eve); if closings are approved, the closing of other department operations will be contingent upon the approval of the respective department/division director. Affected employees will be required to charge hours to accrued vacation or comptime, take hours without pay if no accrued vacation or comptime is available or work hours during closings contingent upon supervisor's approval. You will be advised by your department director if closings are approved from year to year.*

Note: Annual Christmas Barbeque is Friday, December 18, 2015/Civic Center/11:00am – 1:00pm

Benefits/Wellness Program Events/Dates

__Lab Draws/Make-Ups__: To be announced.
__Benefits Fair/Insurance Open/Re-Enrollment Period for all insurance coverage's effective January 1, 2015 – Civic Center:__
Wednesday, October 28/12noon – 5pm; Thursday, October 29/ 7am-5pm; and Friday, October 30/ 7am-12pm.
__Health Fair – Civic Center:__ Thursday, November 19/7am – 12noon.

cc. Division/Department Directors
City Manager
City Commissioners
Employees

City of Rome – In-State
BlueChoice POS 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.

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 ▪ Family	 $1,500 $4,500	 $3,000 $9,000
Coinsurance	Member pays 20% Plan pays 80%	Member pays 40% Plan pays 60%
Benefit Period Out-of-Pocket Maximum* (includes benefit period deductible) ▪ Individual ▪ Family	 $6,850 $13,700	 $9,000 $27,000
Lifetime Maximum	Unlimited	Unlimited

*Deductibles are combined for in-network and out-of-network services. 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 medical and pharmacy copayments, deductible(s), and coinsurance on this plan will apply toward the out-of-pocket maximums. The following do not apply to out-of-pocket maximums: non-covered items, plan premiums, any balance billing due to Out-of-Network 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)* ▪ OB/GYN (no referral) ▪ Specialist Physician (PCP referral required, except dermatologists, ophthalmologists and optometrists for treatment of acute eye conditions) *Also applies to services rendered at Retail Health Clinics	$40 copayment $40 copayment $60 copayment	Member pays 40% after deductible
Maternity Physician Services ▪ 1st Prenatal visit ▪ Global obstetrical care (prenatal, delivery and postpartum services)	$100 copayment Member pays 20 % after deductible	Member pays 40% after deductible Member pays 40% after deductible
Telemedicine Services	$40 PCP copayment or $60 Specialist copayment	Member pays 40% after deductible
Telehealth Services – Online Physician Visit (https://livehealthonline.com)	$40 copayment	Member pays 40% after deductible
Allergy Services ▪ Office visits, testing, serum and the administration of allergy injections	$40 PCP copayment or $60 Specialist copayment	Member pays 40% after deductible

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Office Surgery (surgery and administration of general anesthesia)	Covered in PCP/Specialist copayment	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	$40 copayment $40 copayment	Member pays 40% after deductible Member pays 40% after deductible
Other Therapy Services (chemotherapy, radiation therapy, cardiac rehabilitation [36-visit benefit period maximum] and respiratory/pulmonary therapy 40 visits) ▪ Office setting	$40 PCP copayment or $60 Specialist copayment	Member pays 40% after deductible
▪ Facility setting	Member pays 20% after deductible	Member pays 40% after deductible
▪ Chiropractic care	Not covered	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	$250 copayment; then member pays 20% after deductible	$250 copayment; then member pays 20% after deductible
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 mental health and substance abuse services (physician fee)	$40 copayment	Member pays 40% after deductible
▪ Outpatient mental health and substance abuse services (physician fee)	Member pays 20% after deductible	Member pays 40% after deductible
Home Health Care Visits ▪120-visit benefit period maximum	Member pays 0% after deductible	Member pays 40% after deductible
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% after deductible	Member pays 40% after deductible
Durable Medical Equipment (DME)	Member pays 20% after deductible	Member pays 40% after deductible
Ambulance Services (covered when medically necessary)	Member pays 0% (not subject to deductible)	Member pays 0% (not subject to deductible)
Bariatric Services & Surgery	$2,000 copayment; member pays 40% after copayment and the out-of-network deductible	$2,000 copayment; member pays 40% after copayment and the out-of-network deductible

Prescription Drugs

Note:

- If a member receives a brand name drug that falls on Tier 2 or 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 does not apply when physician indicates DAW (dispense as written) or obtains an authorization.
- All member cost shares (copayments) for pharmacy benefits will apply to the plan Out-Of-Pocket Maximums.

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 and 90 day generic maintenance supplies at one copay)	$25 copayment
▪ Retail Drugs - Tier 2 (30 day supply)	$35 copayment
▪ Retail Drugs - Tier 3 (30 day supply)	$70 copayment
▪ Retail Drugs - Tier 4 (Specialty Drugs) (30 day supply)	$210 copayment
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	$25 copayment
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	$70 copayment
▪ Home Delivery Maintenance Drugs - Tier 3 (90 day supply)	$140 copayment
▪ Home Delivery Maintenance Drugs - Tier 4 (Specialty Drugs) (30 day supply)	$210 copayment

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.

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

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 (the contract) for a complete explanation of covered services, limitations and exclusions.

The Power of Blue℠

3350 Peachtree Road, NE • Atlanta, Georgia 30326 • 1-855-397-9267

Blue Cross Blue Shield Healthcare Plan 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.

Custom Summary (NS)(Orig. Plan GKP5 1.5K/80A)-effective 1/1/2016
Revised 10/21/15 by M. Streitenberger

GROUP HEALTH INSURANCE PREMIUM INFORMATION

(80/20) NON-NICOTINE RATE WITH 10% DISCOUNT FOR WELLNESS PROGRAM PARTICIPATION (NOTE: PPO are the same as POS Option Premums)	BCBS RECOMMENDED PREMIUM FOR EXPECTED CLAIM LIABILITY	**2015 MONTHLY PREMIUM**	ANNUAL PREMIUM	ANNUAL EMPLOYEE CONTRIBUTION 10% Increase	ANNUAL EMPLOYER CONTRIBUTION 8% Increase	RECHECK ANNUAL PREMIUMS	BIWEEKLY EMPLOYEE CONTR	BIWEEKLY EMPLOYER CONTR	MONTHLY EMPLOYEE CONTR	MONTHLY EMPLOYER CONTR	EMPLOYEE COUNT IN EACH PLAN REPORTED BY BCBS	PROJECTED ANNUAL PREMIUMS
EMPLOYEE ONLY	592.54	453.85	5,446.20	1,105.32	4,340.88	5,446.20	42.51	166.96	92.11	361.74	238	1,296,195.60
PREMIUM AMOUNT/OLD RATE				20%	80%		***38.65***		***83.74***			
DOLLAR AMT OF INCREASE					216		3.86		8.37			
NCREASE PERCENTAGE				238,749.12	937,630.08		10.0%		10.0%			
EMPLOYEE ONLY COBRA PREMIUM		***462.93***										
EMPLOYEE + CHILD/CHILDREN	1,173.77	838.09	10,057.04	2,549.02	7,508.02	10,057.04	98.04	288.77	212.42	625.67	56	563,194.24
PREMIUM AMOUNT/OLD RATE				25%	75%		***89.13***		***193.11***			
DOLLAR AMT OF INCREASE					56		8.91		19.31			
NCREASE PERCENTAGE				142,745.12	420,449.12		10.0%		10.0%			
2 PARTY COBRA PREMIUM		***854.85***										
EMPLOYEE + SPOUSE	1,173.77	931.21	11,174.54	2,832.26	8,342.28	11,174.54	108.93	320.86	236.02	695.19	151	1,687,355.54
PREMIUM AMOUNT/OLD RATE				25%	75%		***99.03***		***214.57***			
DOLLAR AMT OF INCREASE					81		9.90		21.45			
NCREASE PERCENTAGE				229,413.06	675,724.68		10.0%		10.0%			
2 PARTY COBRA PREMIUM		***949.83***										
FAMILY (EMP/SP/CHILDREN)	1,488.40	1,316.61	15,763.31	3,995.31	11,768.00	15,763.31	153.67	452.62	332.94	980.67	151	2,380,259.81
PREMIUM AMOUNT/OLD RATE				25%	75%		***139.70***		***302.68***			
DOLLAR AMT OF INCREASE					211		13.97		30.26			
NCREASE PERCENTAGE				843,010.41	2,483,048.00		10.0%		10.0%			
FAMILYCOBRA PREMIUM		***1,339.88***			*5,970,769.59*						596	*5,927,005.19*
							Retiree Annual Prms/Moved to MC Supplement (Humana)					
				Covered Lives	*564.00*					*Total Projected Prms*		
										Spousal Surcharge		
										TOTAL		*$ 5,927,005.19*
NON-NICOTINE RATE/WO DISCOUNT			***COBRA mo prm***	**Employee Annual Contribution**	**City Annual Contribution**		**Employee BW**	**Employer BW**	**Employee Monthly**	**Employer Monthly**		
EMPLOYEE ONLY		499.24	***509.22***	1,215.85			46.76	166.96	101.32	361.74		
EMPLOYEE + CHILD/CHILDREN		921.90	***940.34***	2,803.92			107.84	288.77	233.66	625.67		
EMPLOYEE + SPOUSE		1,024.33	***1,044.82***	3,115.49			119.83	320.86	259.62	695.19		
FAMILY (EMP/SP/CHILD/CHILDREN)		1,444.97	***1,473.87***	4,394.84			169.03	452.62	366.24	980.67		
NICOTINE RATE/W 10% DISCOUNT				**Ann Contri Emp**			**Employee BW**		**Monthly BW**			
EMPLOYEE ONLY		503.85	***513.93***	1,705.32			65.59	166.96	142.11	361.74		
EMPLOYEE + CHILD/CHILDREN		888.09	***905.85***	3,149.02			121.12	288.77	262.42	625.67		
EMPLOYEE + SPOUSE		981.21	***1,000.83***	3,432.26			132.01	320.86	286.02	695.19		
FAMILY (EMP/SP/CHILD/CHILDREN)		1,363.61	***1,390.88***	4,595.31			176.74	452.62	382.94	980.67		
NICOTINE RATE/WO DISCOUNT				**Ann Contri Emp**			**Employee BW**		**Monthly BW**			
EMPLOYEE ONLY		554.24	***565.32***	1,875.85			72.15	166.96	156.32	361.74		
EMPLOYEE + CHILD/CHILDREN		976.90	***996.44***	3,463.92			133.23	288.77	288.66	625.67		
EMPLOYEE + SPOUSE		1,079.33	***1,100.92***	3,775.49			145.21	320.86	314.62	695.19		
FAMILY (EMP/SP/CHILD/CHILDREN)		1,499.97	***1,529.97***	5,054.84			194.42	452.62	421.24	980.67		

NOTE: SPOUSAL COVERAGE $40 PER MONTH (set up under a different deduction code/24 BW pays = $20 per BW payroll)
COBRA PREMIUMS ARE SUBJECT TO 2% ADMINISTRATION FEE ***ALSO REMEMBER THAT CLAIMS ARE PROCESSED ON CALENDAR YEAR.***

Health Care and Managed Care Terms used by Blue Cross and Blue Shield of Georgia

A

Accreditation:
Certification that an organization meets the reviewing organization's standards. Examples: accreditation of HMOs by the National Committee for Quality Assurance (NCQA) or accreditation of PPOs by the American Accreditation HealthCare Commission/URAC.

Acupuncture:
An alternative health procedure based on ancient Chinese methods, gaining acceptance in Western hospitals, involving insertion of thin needles at specific pressure points in the body.

Adjudication:
Determination of the amount of payment for a claim.

Administrative Costs:
The costs assumed by an insurance company or managed care plan for administrative services such as claims processing, billing and overhead costs.

Administrative Services Only (ASO):
An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group but does not assume any financial risk for the payment of benefits.

Agent:
An individual licensed by the State who sells insurance or coverage and provides service to the policyholder on behalf of the insurer or managed care plan. Could be sole-proprietor, member of a large firm or employee of the carrier and is paid a fee/commission by the carrier.

Allergy Treatment:
Treatment of allergy, which may involve allergy testing and physician's services.

Allowable Charge:
The maximum fee that a third party will reimburse a provider for a given service. An allowable charge may not be the same amount as either a reasonable or customary charge.

Ambulatory Care or Services:
Health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients in a hospital.

Ambulatory Surgery:
Surgical procedures performed that do not require an overnight hospital stay. Also called Outpatient Surgery.

American Accreditation HealthCare Commission, Inc./Utilization Review Accreditation Commission, Inc.
(AAHCC/URAC):
An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care providers, consumers, and regulators to encourage more efficient and effective managed care.

Ancillary:
A term used to describe additional services performed related to care, such as lab work, x-ray, and anesthesia.

Ancillary Services:
Hospital services other than room and board, and professional services. They may include X-ray, drug, laboratory or other services.

Anniversary:
The start of a group's benefit plan year, which may not necessarily match the fiscal year used by the group.

Appeal(s):
An individual's dispute over the denial of a claim payment or the denial of provision of a health care service, or a coverage denial based on a contractual exclusion or limitation.

Authorization:
The approval of care, for hospitalization, outpatient procedure, certain specialty, etc., by a managed care or insurance company for its member, subscriber, or insured.

B

Beneficiary:
A person who is eligible to receive insurance benefits.

Benefit:
The amount payable by an insurer or employee benefit plan to a claimant, assignee or beneficiary under the terms of in the benefits contract.

Benefit Consultant:
An individual or organization hired by a group planholder to review, analyze, and make recommendations on benefit
strategies, including benefit plan design, carrier selection, pricing, etc. An insurance professional who provides information, advice and counseling for their clients.

Benefits Package:
A term informally used to refer to the employer's benefit plan or to the benefit plan options from which the employee can choose. "Benefits package" highlights the fact a health benefits plan is a compilation of specific benefits.

Benefit Period:
The maximum length of time for which benefits will be paid.

Birthing Center:
A facility that allows mothers to give birth in a home-like setting.

BlueCard Program:
A BCBSA program that links participating health care providers and the independent Blue Cross and Blue Shield Plans across the country and abroad with a single electronic process for professional, outpatient and inpatient claims processing and reimbursement. The program allows members obtaining health care services while out of town to receive the same benefits of their Blue Cross plan and access out-of-town providers' savings. In most cases, providers bill claims directly to their local Plans without requiring up-front payment from the member.

BlueChoice Healthcare Plan:
BlueChoice Healthcare Plan is a health maintenance organization (HMO) product, underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia.* This plan provides preventive care benefits, as well as coverage for treatment of specific illness and injury. Members receive a high level of benefits with low out-of-pocket costs. *Blue Cross Blue Shield Healthcare Plan of Georgia is an independent licensee of the Blue Cross and Blue Shield Association.

BlueChoice Option:
BlueChoice Option* is a point-of-service plan that offers the advantages of an HMO with the flexibility of a traditional health insurance plan. Members decide where to receive care when they need it at the point-of-service. BlueChoice Option provides two levels of benefits in-network and out-of network. *BlueChoice Option is
underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia, an independent licensee of the Blue Cross and Blue Shield Association.

BlueChoice Platinum:
BlueChoice Platinum is a Medicare + Choice health maintenance organization (HMO) product.* This plan provides preventive care benefits for Medicare beneficiaries, as well as coverage for treatment of specific illness or injury. Members receive a high level of benefits with low out-of-pocket costs. *BlueChoice Platinum is underwritten by
Blue Cross Blue Shield Healthcare Plan of Georgia, an independent licensee of the Blue Cross and Blue Shield Association, and an HMO with a Medicare +Choice contract.

BlueChoice PPO:
BlueChoice PPO is a preferred provider organization (PPO) that offers members the flexibility of going in or out-of-network for medical care. If members see a physician, specialist or hospital that is in-network (a preferred provider), they receive more savings and benefits. *BlueChoice PPO is underwritten by Blue Cross and Blue Shield of
Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Board Certified (Boarded, Diplomate):
Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Brand Name Drug(s):
Those drugs that are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection, meaning the manufacturer is the sole source for the product.

C

Case Management:
A utilization management program that assists the patient in determining the most appropriate and cost effective treatment plan. It is used for patients who have prolonged, expensive or chronic conditions, helps determine the treatment location (hospital, other institution or home) and authorizes payment for such care if it is not covered under the patient's benefit agreement. The purpose of case management is to provide optimum patient care in the most cost effective manner.

Certificate Booklet:
A detailed document that serves both as an explanation of the benefit plan and as the certificate of insurance. See certificate of coverage.

Certificate of Coverage:
A description of the benefits included in an insurance plan. The certificate of coverage is required by state insurance laws and represents the coverage provided under the policy issued to the contract holder. The certificate is provided to subscribers via the Certificate Booklet.

Certification:
See Pre-Certification.

Chemotherapy:
Treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic (Care):
An alternative medicine therapy administered by a provider such as a chiropractor, osteopath or physical therapist. The provider adjusts the spine and joints to treat pain and improve general health.

Claim:
A request for payment for benefits received or services rendered. A billing record is generated and submitted by a provider or subscriber using paper or electronic media.

Coinsurance:
An arrangement under which the member pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the member responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Coinsurance Maximum:
The total amount of coinsurance that an individual pays each year before the carrier pays 100% of allowable charges for covered services. Coinsurance amounts differ with each contract.

Community Health Partnership Network (CHPNs):
Networks constructed as regional delivery systems, integrating the delivery of health care through local partnerships with hospitals, physicians and other business coalitions. The overall concept is based on the belief that health care is best delivered and managed at the local level.

Concurrent Review:
A component of Utilization Management program which evaluates a member's coverage for hospital services under the terms of the contract.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA):
The federal law that requires employers with more than 20 employees to extend group health insurance coverage for up to 36 months after a qualifying event (e.g. termination of employment, reduction in hours, divorce). The law contains detail provisions relating, among other things, to an employer's obligation to provide notice of these rights and the circumstances under which such continuation may end.

Continuation:
See COBRA.

Contraception:
Prevention of pregnancy or birth control.

Contract:
A binding written agreement between the insurer and policyholder to evidence the terms and conditions of the policy. The contract between Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia and an insured includes the certificate booklet. Can also be called a Benefit Certificate or Policy.

Contract Holder:
See Subscriber.

Conversion Option: The exercise of an option to purchase individual coverage at a negotiated rate by a person who is leaving an employee group, typically at retirement.

Coordination of Benefits:
The non-duplication provision to limit benefits for multiple group health insurance in a particular case to 100% of the covered charges and to designate the order in which the multiple carriers are to pay benefits. Under a COB provision, one Plan is determined to be primary and its benefits are applied to the claim. The unpaid balance is usually paid by the secondary Plan to the limit of its liability.

Copayment or Copay:
The small payment made by a member of an HMO or point-of-service or the user of a PPO at the time a selected service is rendered. This is usually a percentage of the charges but may also be a dollar amount for specified services. Examples include copayment for each physician's office visit and for each hospital admission.

Cost Containment:
A set of programs to reduce use of unnecessary or inappropriate services and to encourage provisions of necessary and appropriate services in a cost-effective manner.

Covered Medical Expense:
Those expenses payable according to the terms of the member contract. The charges for these services are still subject to any cost sharing components or limits, such as deductibles, coinsurance, copayments and maximums, included in the contract.

Covered Person:
An individual who meets eligibility requirements and for whom premium payments are paid for specified benefits of the contractual agreement.

Covered Services:
Hospital, medical and other health care expenses incurred by the covered person that entitle him/her to benefits under a contract. The term defines the type and amount of expense, which will be considered in the calculation of benefits.

Credentialing:
The process of reviewing a provider's credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for inclusion in a network are met. Blue Cross and Blue Shield of Georgia and Blue Cross Blue Shield Healthcare Plan of Georgia thoroughly qualify and carefully screen all physicians in their networks. Each physician must meet specific educational and medical practice standards in order to become part of the network.

Custodial Care: Care provided primarily to assist a patient in meeting the activities of daily living, but not care requiring skilled nursing services.

Customary and Reasonable (C&R):
The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and the reasonable cost of services for a given patient after medical review of the case.

D

Day Treatment Center:
An outpatient psychiatric facility that is licensed to provide outpatient care and treatment of mental or nervous disorders or substance abuse under the supervision of physicians.

Deductible:
The amount of covered expenses that must be incurred by each member before benefits become payable by the insurer. For example, if a plan has a $100 deductible, the deductible is met once the first $100 of the covered medical expenses for that year have been paid. After that, the plan begins to pay toward the cost of covered health care services.

Dental Care:
Under a medical plan, dental care is dental treatment which due to the nature of the procedure or patient's medical condition, may be provided in a hospital setting.

Dependent:
Person, (spouse or child), other than the subscriber who meet eligibility requirements under the subscriber's benefit certificate.

Diagnostic Tests:
Tests and procedures ordered by a physician to determine if the patient has a certain condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include radiology, ultrasound, nuclear medicine, laboratory, pathology services or tests.

Discharge Planning:
Component of Utilization Management program which evaluates a member's coverage under the terms of the member's contract for health care services after discharge from an inpatient setting.

Disease Management Programs (Health Management Programs):
Educational programs designed for individuals with chronic diseases designed to help maintain high quality of life and prevent future need for medical resources by using an integrated, comprehensive approach to health care coordinate with the individual's physician. Pharmaceutical care, continuous quality improvement, practice guidelines, and case management all play key roles in this effort.

Drug Formulary:
A list of preferred pharmaceutical products that health plans, working with an expert panel of pharmacists and physicians, have developed to encourage the dispensing of quality, cost effective medications. The list is subject to periodic review and modification by the health plan.

Durable Medical Equipment (DME):
Mechanical devices, equipment and supplies that enable a person to maintain functional ability.

E

Effective Date:
The date on which the coverage or a change in coverage of a contract goes into effect at 12:01 a.m.

Eligibility:
The provisions of the group policy or insurance contract that state requirements that applicants must satisfy to become insured with respect to themselves or their dependents.

Emergency:
A condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing 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 result in: Placing the member's health in serious jeopardy; Serious impairment to bodily functions; Serious dysfunction of any bodily organ or part; or Other serious medical consequences. Such conditions include but are NOT limited to: chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and other acute conditions.

Emergency Care:
Care for patients with severe or life threatening conditions that require immediate medical attention.

Employee Assistance Program (EAP):
A worksite-based program that is designed to assist in the identification and resolution of productivity problems associated with personal concerns of employees. The program provides employees and their dependents with access to confidential, short-term counseling by qualified practitioners, in person or over the phone.

Employee Retirement Income Security Act (ERISA):
A federal act, passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs.

Employer Group:
A group of eligible employees to whom health care benefits are extended through a benefits plan provider. The relationship is formalized through a contract. For the employer group to be recognized, a true employee-employer relationship must exist. Examples of groups which would not qualify include social clubs and independent contractors.

Encounter:
Information submitted by a capitated provider to establish that medical services were provided to a covered person.

Enrollee:
An individual who is enrolled and eligible for coverage under a health plan contract. Synonymous with member.

Exclusions:
Specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.

Experimental Procedures:
Procedures that are not recognized under generally accepted medical standards as safe and effective for treating a particular condition.

Expiration Date:
The date coverage expires.

Explanation of Benefits (EOB):
A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

F

Fee-for-Service Reimbursement:
A method of reimbursement by which a provider charges, and is reimbursed, separately for each patient encounter or service rendered.

FEP:
The "Federal Employee Program" is a group contract to provide health care benefits to federal employees, underwritten by Blue Cross and Blue Shield Plans. The official name of the program is the Government-Wide Service Benefit Plan.

FLEXPLUS:
FLEXPLUS* is comprehensive major medical health plan that allows members to visit any physician or hospital they choose. This plan provides extensive benefits for individuals and families who do not have access to group health coverage. *FLEXPLUS is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Formulary:
See Drug Formulary.

Full-Time Employee: An employee who meets the eligibility requirements for full-time employees as outlined in the Benefit Agreement.

G

Gatekeeper: Term given to a primary care provider who coordinates all medical care for a patient and determines whether services such as tests or referral to a specialist are necessary.

Generic Prescription Drug (generic drug):
Safe, effective and equivalent to brand name medications that may cost considerably less than the brand name medications. Generic drugs must meet the same high standards of quality as brand name drugs and are formulated to have the same effect in the body as the brand name version. Generic drugs often become available when a brand name drug's patent expires.

Group Health Coverage:
A health benefits plan that covers a group of people as permitted by state and federal law.

H

Health Benefit Plan:
A health insurance product offered by a health plan company that is defined by the benefit contract and represents a set of covered services and a provider network.

Health Care Financing Administration (HCFA):
Federal government agency that administers Medicare and Medicaid.

Health Insurance Portability and Accountability Act (HIPAA):
A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, restricts pre-existing condition exclusion periods to ensure portability of health-care coverage between plans, group and individual; requires guaranteed issue and renewal of insurance coverage; prohibits plans from charging individuals higher premiums, co-payments, and/or deductibles based on health status.

Health Maintenance Organization (HMO):
An organized system of health care that assures the delivery of a comprehensive range of health services to members who enroll voluntarily and pay a fixed, prepaid fee. Such services include a wide variety of medical treatments and counsel, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services. Members are generally limited to using providers designated by the HMO.

Hearing Services:
Testing and services related to hearing.

HEDIS®:
Health Plan Employer Data and Information Set (HEDIS®), the nation's premier measurement tool for managed care quality and service, is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.

Blue Cross Blue Shield Healthcare Plan of Georgia:
BlueChoice Healthcare Plan is a health maintenance organization (HMO) product, underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia.* This plan provides preventive care benefits, as well as coverage for treatment of specific illness and injury. Members receive a high level of benefits with low out-of-pocket costs *Blue Cross Blue Shield Healthcare Plan of Georgia is an independent licensee of the Blue Cross and Blue Shield Association.

HMO:
See Health Maintenance Organization.

Home Health Agency:
A facility or program licensed, certified or otherwise authorized pursuant to state and federal laws as a home health agency; approved by the health plan to provide health services covered under the contract.

Home Health Care:
Health services rendered to an individual as needed in the home. Such services are provided to aged, disabled, sick or convalescent individuals who do not need institutional care.

Home Infusion Therapy: The administration of intravenous drug therapy in the home. Home infusion therapy includes the following services: solutions and pharmaceutical additives; pharmacy compounding and dispensing services; durable medical equipment; ancillary medical supplies; and nursing services.

Hospice:
A facility or service that provides care for terminally ill patients and support to their families, either directly or on a consulting basis with the patient's physician. Emphasis is on symptom control and support before and after death.

Hospital:
An institution whose primary function is to provide inpatient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and non-surgical. In addition, most hospitals provide some outpatient services, particularly emergency care.

I

ID Card/Identification Card:
See Member ID Card

Immunizations:
Specific types of injections to prevent infectious diseases and viral infections.

In-Network:
In-network means seeing a provider that has contracted with Blue Cross and Blue Shield of Georgia and/or Blue Cross Blue Shield Healthcare Plan of Georgia to participate in the network of physicians and hospitals.

Indemnity:
Indemnity or "traditional" insurance is a plan which reimburses physicians of covered charges for services performed, or insures for medical expenses incurred.

Individual Insurance:
Health care coverage for individuals or single family units.

Infertility:
Term used to describe the inability to conceive or an inability to carry a pregnancy to a live birth. Also includes the presence of a condition recognized by a physician as the cause of infertility.

Infusion Therapy:
The administration of intravenous drug therapy. Infusion therapy includes the following services: solutions and pharmaceutical additives; pharmacy compounding and dispensing services; durable medical equipment; ancillary medical supplies; and nursing services.

Inpatient:
A person admitted to a hospital as a bed patient for more than a specific number of hours.

Investigative Procedures or Medications:
Those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

L

Length of Stay (LOS):
The number of days that a member stayed in an inpatient facility.

Lifetime Maximum:
Maximum amount the plan will pay toward a member's coverage in a lifetime. The amount varies depending on the type of coverage the member carries.

M

Managed Care:
A prepaid health plan or insurance program in which beneficiaries receive medical service in a coordinated manner to eliminate unnecessary medical services. In managed care health plans, the member seeks specialist or hospital care after prior approval of coverage by designated health care professionals, such as primary care physicians, utilization review nurses, or employer-designated professionals. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

Maternity Care:
The care of women before and during childbirth as well as the care of newborn babies.

Medical Equipment: See Durable Medical Equipment.

Medical Necessity:
The Plan only pays the cost of covered services it considers medically necessary under the terms of the member's contract. The Plan reserves the right to determine whether a service or supply is medically necessary. The fact that a physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it medically necessary and a covered service. A service is considered medically necessary if it is:

Appropriate and consistent with the diagnosis and could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; Compatible with the standards of acceptable medical practice in the United States; Provided not solely for a member's convenience or the convenience of the physician or hospital; Not primarily custodial care; and, The least costly level of service that can be safely provided. For example, a hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

Medicare:
Title XVIII of the Social Security Act which provides a hospital and medical insurance program for the aged, totally disabled, and those with end-stage renal disease (ESRD). There are two parts – A and B. Part A is the hospital portion and is mandatory for all eligibles. Those who elect part B coverage, pay an additional premium to the federal government.

Member:
An individual or dependent who is enrolled in and covered by a health care plan. Also called enrollee or beneficiary.

Member Handbook:
A booklet that highlights the basic elements of a member's health care coverage as well as special features that may be specific to their plan. Each member receives a member handbook.

Member ID Card:
A card given to each member by Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia which introduces the member to physicians and hospitals. Although the cards do not guarantee eligibility for medical care benefits at any given time, they increase the convenience of obtaining health insurance services. The card is subsequently used by the provider to determine benefit levels and to prepare billing statement.

Mental Health/Behavioral Health:
Conditions that affect thinking and the ability to figure things out which affect perceptions, mood and behavior. Such disorders are recognized primarily by symptoms or signs that appear as distortions of normal thinking or distortions of the way things are perceived (seeing or hearing things that are not there). Disorders can also be recognized by moodiness, sudden or extreme changes in mood, depression, and highly agitated or unusual behavior.

N

NCQA:
The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization dedicated to measuring the quality of America's health care. NCQA's mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed decisions. The NCQA Accreditation survey process included rigorous on-site and off-site evaluations of over 60 standards and selected HEDIS® performance measures. A team of physicians and managed care experts conducts Accreditation surveys. A national oversight committee of physicians analyzes the team's findings and assigns an accreditation level based on the performance level of each plan being evaluated to NCQA's
standards.

Negotiated Rate:
The amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Network:
A group of health care providers under contract with Blue Cross and Blue Shield of Georgia within a specific geographic area.

Network Provider:
See Provider Network.

Non-Participating Provider:
A non-participating provider is a physician, hospital or other medical provider that has not entered into a service agreement with Blue Cross and Blue Shield of Georgia to provide benefits upon certain terms including specified rates.

O

Occupational Therapy:
Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, toiling and bathing.

Open Enrollment:
A period when eligible persons can enroll in a health benefits plan.

Out-Of-Network:
The use of health care providers who have not contracted with the carrier to provide services. HMO members are generally not reimbursed if they go out-of-network except in emergency situations. Covered persons of preferred provider organizations and HMOs with point-of-service options may go out-of-network, but must pay additional costs including deductibles and coinsurance.

Out-Of-Pocket:
Those medical expenses which an insured is required to pay because they are not covered under the group contract.

Out-Of-Pocket Maximum:
Refers to the maximum amount that a covered person will have to pay for expenses covered under the plan. It is a sum of deductible and coinsurance amounts.

Outpatient:
A patient who visits a clinic or hospital to receive medical diagnosis or treatment, but does not occupy a hospital bed for a specified minimum stay.

Outpatient Surgery:
Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center or physician office.

P

Partial Day Treatment:
A program offered by appropriately licensed psychiatric facilities that includes either a day or evening treatment program for mental health or substance abuse. Such care is an alternative to inpatient treatment.

Participating Provider:
A participating provider is a physician, hospital or other medical provider that has entered into a service agreement with Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia to provide benefits upon certain terms including specified rates.

PCP:
See Primary Care Physician.

Per Member Per Month (PM/PM):
The unit of measure related to each effective member for each month the member was effective. The calculation is: # of units/member months (MM).

Physician's Current Procedural Terminology (CPT):
A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting physician procedures and services, thereby providing an effective method of nationwide communication.

Physical Therapy:
Treatment involving physical movement to relieve pain, restore function and prevent disability following disease, injury or loss of limb.

Plan Benefit Maximum:
Maximum amount the carrier will pay toward an individual's coverage. The amount varies depending on the type of coverage the individual carries.

Point-of-Service (POS):
An option provided by some HMOs that allows covered persons to go outside the plan's provider network for care, but requires they pay higher cost-sharing than they would for network providers.

Pre-admission Certification:
A component of a Utilization Management program which reviews an inpatient hospital stay prospectively to determine coverage.

Preauthorization:
A prospective process to verify coverage of proposed care, to establish covered length of stay and to set a date for concurrent review.

Pre-Certification:
Refers to certifying the medical necessity and level of care in advance. Pre-certification does not guarantee that contract benefits will be available.

Pre-Certification Review:
Utilization management performed prior to a patient's admission, stay, or other service or course of treatment. Also known as Prior Authorization.

Pre-Existing Condition: A health condition or medical problem that was diagnosed or treated before enrollment in a new health plan or insurance policy. Some pre-existing conditions may be excluded from coverage.

Preferred Provider Organization (PPO):
A network of hospitals and physicians who agree to provide services at less than their usual fees. Members of this type of product may incur out-of-pocket expenses for covered services received outside the PPO if the charge exceeds the PPO payment rate. The PPO does not assume insurance risk, and it does not facilitate the sharing of risk by its covered persons.

Prescription:
A written order or refill notice issued by a licensed medical professional for drugs, which are only available through a pharmacy.

Preventive Care:
Proactive health care designed to keep people from getting sick or hurt. It includes immunizations and screenings. A key part of preventive medicine is making sure patients know how to improve their health by altering their lifestyles. Refers to certifying the medical necessity and level of care in advance.

Primary Care Physician (PCP):
A primary care physician is a physician who is a family or general practitioner, internist or pediatrician. PCPs provide a broad range of routine medical services and refers patients to specialists, hospital and other providers as necessary. Each covered family member who participates in BlueChoice Healthcare Plan or BlueChoice Option,
chooses his or her own PCP from the network's physicians.

Prior Authorization: The process of obtaining pre-approval of coverage for a health care service or medication.

Prosthetic Devices: A device that replaces all or a portion of a part of the human body. These devices are necessary because a part of the body is permanently damaged, is absent or is malfunctioning.

Provider:
A licensed health care facility, program, agency or health professional that delivers health care services.

Provider Network: That set of providers contracted with a health plan to provide services to the enrollees. In the case of a "fee-for-service" or non-network health plan, the provider network is generally all licensed providers of covered services.

R

Radiation Therapy:
Treatment of disease by x-ray, radium, cobalt or high energy particle sources.

Reasonable and Customary:
The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community) and the reasonable cost of services for a given patient after medical review of the case. Also known as Usual and Customary (U&C) or Customary and Reasonable (C&R).

Referral:
If a primary care physician (PCP) determines a member has a condition which requires the attention of a specialist, the PCP makes a referral to a specialist. Members of BlueChoice Healthcare Plan must receive a referral prior to seeing most specialists in order to receive their full benefits. BlueChoice Option members can opt to self-refer but benefits will be paid at a reduced level.

Respiratory Therapy:
Treatment of illness or disease that is accomplished by introducing dry or moist gases into the lungs.

Retrospective Review:
A review of claims and medical records for medical necessity and appropriateness after the episode of care is concluded and before and/or after the claim is submitted by the provider.

S

Second Opinion:
The voluntary option or mandatory requirement to visit another physician or surgeon regarding diagnosis, course of treatment or having specific types of elective surgery performed.

Service Area:
The geographic area a provider network designates as its boundary limits for enrolling members.

Skilled Nursing Facility:
An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services.

Specialists:
Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat), or specific procedures (e.g., oral surgery).

Speech Therapy: Treatment or the correction of a speech impairment that resulted from birth, or from disease, injury or prior medical treatment.

Subscriber:
The individual in whose name a contract is issued or the employee covered under an employer's group health contract.

Substance Abuse/Chemical Dependency:
Conditions that include, but are not limited to (1) psychoactive substance induced mental disorders; (2) psychoactive substance use dependence; and (3) psychoactive substance use abuse. Chemical dependency does not include addition to or dependency on, tobacco or food substances (or dependency on items not ingested).

65PLUS:
65PLUS* offers Medicare beneficiaries a choice of five of the federally approved Medicare supplement plans: Plans A, B, C, E and F. Because Medicare only pays a portion of hospital and physician charges, these supplements provide certain benefits otherwise unavailable from Medicare.
*65PLUS is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Urgent Care:
The services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, that requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

Usual, Customary and Reasonable:
A "usual" charge is the amount that is most consistently charged by an individual physician for a given service. A "customary" charge is the amount that falls within a specified range of usual charges for a given service billed by most physicians with similar training and experience within a given geographic area. A "reasonable" charge is a charge that meets the Usual and Customary criteria, or is otherwise reasonable in light of the complexity of treatment of the particular case. Under a UCR Program, the payment is the lowest of the actual billed charge, the physician's usual charge or the area customary charge for any given covered service.

U

Utilization Management:
The process of evaluating a proposed hospitalization, service, or procedure and determining whether the hospitalization, service or procedure meets established guidelines and criteria to be covered under a member's contract.

Utilization Review:
A review process designed to evaluate the appropriateness of health care services.

W

Well Baby/Well Child Care:
Routine care, testing, checkups and immunizations for a generally healthy child from birth through the age of six.

Wellness Program:
A health management program that incorporates the components of disease prevention, medical self-care, and health promotion. It utilizes proven health behavior techniques that focus on preventive illness and disability, which respond positively to lifestyle related interventions. Programs are designed to integrate with existing health care benefits; e.g., flex benefits, HMO, PPO; support the reduction in the demand for health care resources; and address the issues of dependent coverage and services for high-risk employees.

8.06 Leave Accrual Tables – General Service P.T. Employees/20 – 24 hrs.

VACATION LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. PT/20 hrs.			Annual Default Limit
Months	Ann	BW	
0-11	20	0.7692	40
12-59	40	1.5385	80
60-71	44	1.6923	88
72-83	48	1.8462	96
84-95	52	2.0000	104
96-107	56	2.1538	112
108-119	60	2.3077	120
120-131	64	2.4615	128
132-143	68	2.6154	136
144-155	72	2.7692	144
156-167	76	2.9231	152
168-179	80	3.0769	160
180-191	80	3.0769	160
192-203	84	3.2308	168
204-215	84	3.2308	168
216-227	88	3.3846	176
228-239	88	3.3846	176
240-251	92	3.5385	184
252-263	92	3.5385	184
264-275	96	3.6923	192
276-287	96	3.6923	192
288-999	100	3.8462	200

General Svc. PT/24 hrs.			Annual Default Limit
Months	Ann	BW	
0-11	24	0.9231	48
12-59	48	1.8462	96
60-71	53	2.0308	106
72-83	58	2.2154	115
84-95	62	2.4000	125
96-107	67	2.5846	134
108-119	72	2.7692	144
120-131	77	2.9538	154
132-143	82	3.1385	163
144-155	86	3.3231	173
156-167	91	3.5077	182
168-179	96	3.6923	192
180-191	96	3.6923	192
192-203	101	3.8769	202
204-215	101	3.8769	202
216-227	106	4.0615	211
228-239	106	4.0615	211
240-251	110	4.2462	221
252-263	110	4.2462	221
264-275	115	4.4308	230
276-287	115	4.4308	230
288-999	120	4.6154	240

SICK LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. PT/20 hrs.		
Months	Ann	BW
1-999	48	1.8462

General Svc. PT/24 hrs.		
Months	Ann	BW
1-999	57.6	2.2154

HOLIDAY HOURS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. PT/20 hrs.
4 hours

General Svc. PT/24 hrs.
4.8 hours

8.07 Leave Accrual Tables – General Service P.T. Employees/25 – 29hrs.

VACATION LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc PT/25 hrs.			Annual Default Limit
Months	Ann	BW	
0-11	25	0.9615	50
12-59	50	1.9231	100
60-71	55	2.1154	110
72-83	60	2.3077	120
84-95	65	2.5000	130
96-107	70	2.6923	140
108-119	75	2.8846	150
120-131	80	3.0769	160
132-143	85	3.2692	170
144-155	90	3.4615	180
156-167	95	3.6538	190
168-179	100	3.8462	200
180-191	100	3.8462	200
192-203	105	4.0385	210
204-215	105	4.0385	210
216-227	110	4.2308	220
228-239	110	4.2308	220
240-251	115	4.4231	230
252-263	115	4.4231	230
264-275	120	4.6154	240
276-287	120	4.6154	240
288-999	125	4.8077	250

General Svc. PT/29 hrs.			Annual Default Limit
Months	Ann	BW	
0-11	29	1.1154	58
12-59	58	2.2308	116
60-71	64	2.4538	128
72-83	70	2.6769	139
84-95	75	2.9000	151
96-107	81	3.1231	162
108-119	87	3.3462	174
120-131	93	3.5692	186
132-143	99	3.7923	197
144-155	104	4.0154	209
156-167	110	4.2385	220
168-179	116	4.4615	232
180-191	116	4.4615	232
192-203	122	4.6846	244
204-215	122	4.6846	244
216-227	128	4.9077	255
228-239	128	4.9077	255
240-251	133	5.1308	267
252-263	133	5.1308	267
264-275	139	5.3538	278
276-287	139	5.3538	278
288-999	145	5.5769	290

SICK LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. PT/25 hrs.		
Months	Ann	BW
1-999	60	2.3077

General Svc PT/29 hrs.		
Months	Ann	BW
1-999	69.6	2.6769

HOLIDAY HOURS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. PT/25 hrs.
5 hours

General Svc. PT/29 hrs.
5.8 hours

8.08 Leave Accrual Tables – General Service F.T. Employees/30 – 32 hrs.

VACATION LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. PT/30 hrs.			Annual Default Limit
Months	Ann	BW	
0-11	30	1.1538	60
12-59	60	2.3077	120
60-71	66	2.5385	132
72-83	72	2.7692	144
84-95	78	3.0000	156
96-107	84	3.2308	168
108-119	90	3.4615	180
120-131	96	3.6923	192
132-143	102	3.9231	204
144-155	108	4.1538	216
156-167	114	4.3846	228
168-179	120	4.6154	240
180-191	120	4.6154	240
192-203	126	4.8462	252
204-215	126	4.8462	252
216-227	132	5.0769	264
228-239	132	5.0769	264
240-251	138	5.3077	276
252-263	138	5.3077	276
264-275	144	5.5385	288
276-287	144	5.5385	288
288-999	150	5.7692	300

General Svc. PT/32 hrs.			Annual Default Limit
Months	Ann	BW	
0-11	32	1.2308	64
12-59	64	2.4615	128
60-71	70	2.7077	141
72-83	77	2.9538	154
84-95	83	3.2000	166
96-107	90	3.4462	179
108-119	96	3.6923	192
120-131	102	3.9385	205
132-143	109	4.1846	218
144-155	115	4.4308	230
156-167	122	4.6769	243
168-179	128	4.9231	256
180-191	128	4.9231	256
192-203	134	5.1692	269
204-215	134	5.1692	269
216-227	141	5.4154	282
228-239	141	5.4154	282
240-251	147	5.6615	294
252-263	147	5.6615	294
264-275	154	5.9077	307
276-287	154	5.9077	307
288-999	160	6.1538	320

SICK LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. FT/30 hrs.		
Months	Ann	BW
1-999	72	2.7692

General Svc. FT/32 hrs.		
Months	Ann	BW
1-999	76.8	2.9538

HOLIDAY HOURS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. FT/30 hrs.
6 hours

General Svc. FT/32 hrs.
6.4 hours

8.09 Leave Accrual Tables – General Service F.T. Employees/35 – 36 hrs.

VACATION LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. PT/35 hrs.			Annual Default Limit	General Svc. PT/36 hrs.			Annual Default Limit
Months	Ann	BW		Months	Ann	BW	
0-11	35	1.3462	70	0-11	36	1.3846	72
12-59	70	2.6923	140	12-59	72	2.7692	144
60-71	77	2.9615	154	60-71	79	3.0462	158
72-83	84	3.2308	168	72-83	86	3.3231	173
84-95	91	3.5000	182	84-95	94	3.6000	187
96-107	98	3.7692	196	96-107	101	3.8769	202
108-119	105	4.0385	210	108-119	108	4.1538	216
120-131	112	4.3077	224	120-131	115	4.4308	230
132-143	119	4.5769	238	132-143	122	4.7077	245
144-155	126	4.8462	252	144-155	130	4.9846	259
156-167	133	5.1154	266	156-167	137	5.2615	274
168-179	140	5.3846	280	168-179	144	5.5385	288
180-191	140	5.3846	280	180-191	144	5.5385	288
192-203	147	5.6538	294	192-203	151	5.8154	302
204-215	147	5.6538	294	204-215	151	5.8154	302
216-227	154	5.9231	308	216-227	158	6.0923	317
228-239	154	5.9231	308	228-239	158	6.0923	317
240-251	161	6.1923	322	240-251	166	6.3692	331
252-263	161	6.1923	322	252-263	166	6.3692	331
264-275	168	6.4615	336	264-275	173	6.6462	346
276-287	168	6.4615	336	276-287	173	6.6462	346
288-999	175	6.7308	350	288-999	180	6.9231	360

General Svc. FT/35 hrs.		
Months	Ann	BW
1-999	84	3.230 8

General Svc. FT/36 hrs.		
Months	Ann	BW
1-999	86.4	3.323 1

General Svc. FT/35 hrs.
7 hours

General Svc. FT/36 hrs.
7.2 hours

8.10 Leave Accrual Tables – General Service F.T. Employees/38 – 40 hrs.

VACATION LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

General Svc. PT/38 hrs.			Annual Default Limit	General Svc. PT/40 hrs.			Annual Default Limit
Months	Ann	BW		Months	Ann	BW	
0-11	38	1.4615	76	0-11	40	1.5385	80
12-59	76	2.9231	152	12-59	80	3.0769	160
60-71	84	3.2154	167	60-71	88	3.3846	176
72-83	91	3.5077	182	72-83	96	3.6923	192
84-95	99	3.8000	198	84-95	104	4.0000	208
96-107	106	4.0923	213	96-107	112	4.3077	224
108-119	114	4.3846	228	108-119	120	4.6154	240
120-131	122	4.6769	243	120-131	128	4.9231	256
132-143	129	4.9692	258	132-143	136	5.2308	272
144-155	137	5.2615	274	144-155	144	5.5385	288
156-167	144	5.5538	289	156-167	152	5.8462	304
168-179	152	5.8462	304	168-179	160	6.1538	320
180-191	152	5.8462	304	180-191	160	6.1538	320
192-203	160	6.1385	319	192-203	168	6.4615	336
204-215	160	6.1385	319	204-215	168	6.4615	336
216-227	167	6.4308	334	216-227	176	6.7692	352
228-239	167	6.4308	334	228-239	176	6.7692	352
240-251	175	6.7231	350	240-251	184	7.0769	368
252-263	175	6.7231	350	252-263	184	7.0769	368
264-275	182	7.0154	365	264-275	192	7.3846	384
276-287	182	7.0154	365	276-287	192	7.3846	384
288-999	190	7.3077	380	288-999	200	7.6923	400

General Svc. FT/38 hrs.		
Months	Ann	BW
1-999	91.2	3.5077

General Svc FT/40 hrs.		
Months	Ann	BW
	96	3.6923

General Svc. FT/38 hrs.
7.6 hours

General Svc. FT/40 hrs.
8 hours

8.11 Leave Accrual Tables – Sworn Hourly Shift Investigator, W & WW Shift Positions or Firefighters

VACATION LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

Sworn Shift, *Investigation and Training Bureaus includes Holiday Hours			W & WW Shift positions Includes Shift Work Incentive			24/48hr Shift FF includes Holiday Hours		
Months	Ann	BW	Months	Ann	BW	Months	Ann	BW
0-11	108	4.1538	0-11	48	1.8462	0-11	151	5.8077
12-59	148	5.6923	12-59	96	3.6923	12-59	207	7.9615
60-71	156	6.0000	60-71	104	4.0000	60-71	218	8.3846
72-83	164	6.3077	72-83	112	4.3077	72-83	230	8.8462
84-95	172	6.6154	84-95	120	4.6154	84-95	241	9.2692
96-107	180	6.9231	96-107	128	4.9231	96-107	252	9.6923
108-119	188	7.2308	108-119	144	5.5385	108-119	263	10.1154
120-131	196	7.5385	120-131	152	5.8462	120-131	274	10.5385
132-143	204	7.8462	132-143	160	6.1538	132-143	286	11.0000
144-155	212	8.1538	144-155	168	6.4615	144-155	297	11.4231
156-167	220	8.4615	156-167	176	6.7692	156-167	308	11.8462
168-179	228	8.7692	168-179	192	7.3846	168-179	319	12.2692
180-191	228	8.7692	180-191	192	7.3846	180-191	319	12.2692
192-203	236	9.0769	192-203	200	7.6923	192-203	330	12.6923
204-215	236	9.0769	204-215	200	7.6923	204-215	330	12.6923
216-227	244	9.3846	216-227	208	8.0000	216-227	342	13.1538
228-239	244	9.3846	228-239	208	8.0000	228-239	342	13.1538
240-251	252	9.6923	240-251	216	8.3077	240-251	353	13.5769
252-263	252	9.6923	252-263	216	8.3077	252-263	353	13.5769
264-275	260	10.0000	264-275	224	8.6154	264-275	364	14.0000
276-287	260	10.0000	276-287	224	8.6154	276-287	364	14.0000
288-999	268	10.3077	288-999	240	9.2308	288-999	375	14.4231

Sworn/Gen Svc. FT/40 hrs.			Gen Svc. FT/40 hrs. (WW)			24Hr Shift Firefighter		
Months	Ann	BW	Months	Ann	BW	Months	Ann	BW
	96	3.6923		96	3.6923	1-999	144	5.5380

Sworn NE Off/Trng/Det.	WW FT/40 hrs.	24Hr Shift Firefighter
0 hours	8 hours	0 hours

*Only applies to non-exempt (hourly) positions in the Investigation and Training Bureaus.

8.12 Leave Accrual Tables –DDA Parking Services PT Employees/20/25 hrs.

PARTTIME ACCRUALS WERE APPLIED TO DDA/PARKING SERVICES August 1, 2008

DDA Gen Svc. PT/20 hrs. Includes Holiday Hrs.			
Months	Ann	Wkly.	BW
0-11	20	0.3846	0.7692
12-59	40	0.7692	1.5385
60-71	44	0.8462	1.6923
72-83	48	0.9231	1.8462
84-95	52	1.0000	2.0000
96-107	56	1.0769	2.1538
108-119	60	1.1538	2.3077
120-131	64	1.2308	2.4615
132-143	68	1.3077	2.6154
144-155	72	1.3846	2.7692
156-167	76	1.4615	2.9231
168-179	80	1.5385	3.0769
180-191	80	1.5385	3.0769
192-203	84	1.6154	3.2308
204-215	84	1.6154	3.2308
216-227	88	1.6923	3.3846
228-239	88	1.6923	3.3846
240-251	92	1.7692	3.5385
252-263	92	1.7692	3.5385
264-275	96	1.8462	3.6923
276-287	96	1.8462	3.6923
288-999	100	1.9231	3.8462

DDA Gen Svc. PT/25 hr. Includes Holiday Hrs.			
Months	Ann	Wkly.	BW
0-11	25	0.4808	0.9615
12-59	50	0.9615	1.9231
60-71	55	1.0577	2.1154
72-83	60	1.1538	2.3077
84-95	65	1.2500	2.5000
96-107	70	1.3462	2.6923
108-119	75	1.4423	2.8846
120-131	80	1.5385	3.0769
132-143	85	1.6346	3.2692
144-155	90	1.7308	3.4615
156-167	95	1.8269	3.6538
168-179	100	1.9231	3.8462
180-191	100	1.9231	3.8462
192-203	105	2.0192	4.0385
204-215	105	2.0192	4.0385
216-227	110	2.1154	4.2308
228-239	110	2.1154	4.2308
240-251	115	2.2115	4.4231
252-263	115	2.2115	4.4231
264-275	120	2.3077	4.6154
276-287	120	2.3077	4.6154
288-999	125	2.4038	4.8077

SICK LEAVE ACCRUALS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

DDA Gen Svc. PT/20 hrs.			
Months	Ann	Wkly.	BW
1-999	48	0.9231	1.8462

DDA Gen Svc. PT/25 hrs.			
Months	Ann	Wkly.	BW
1-999	60	1.1538	2.3077

HOLIDAY HOURS BASED ON THE NUMBER OF HOURS AUTHORIZED FOR THE POSITION PER WEEK

DDA Gen Svc. PT/20 hrs.
0 hrs.

DDA Gen Svc. PT/25 hrs.
0 hrs.