



Douglas County BOC

Blue Open Access POS Benefit Summary (NG)

All benefits are subject to the calendar year deductible, except those with in-network copayments, unless otherwise noted. 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. No primary care physician (PCP) selection or referrals are required.

When using out-of-network providers, members are responsible for any difference between the allowed amount & actual charges, as well as any copayments, deductibles and/or applicable coinsurance.

Deductibles, Coinsurance and Maximums	In-Network Benefit Level	Out-of-Network Benefit Level
Calendar Year Deductible (combined for in- and out-of-network); <i>one deductible for employee, one for spouse, one for all eligible children combined</i> <ul style="list-style-type: none"> - Employee - Employee + Spouse - Employee + Child(ren) - Family 	\$750 \$1,500 \$1,500 \$2,250	\$750 \$1,500 \$1,500 \$2,250
Coinsurance	Plan pays 80% after deductible Member pays 20% after deductible	Plan pays 60% after deductible Member pays 40% after deductible
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Calendar Year Maximum* <ul style="list-style-type: none"> - Employee - Employee + Spouse - Employee + Child(ren) - Family 	\$1,250 \$2,500 \$2,500 \$3,750	\$3,000 \$6,000 \$6,000 \$9,000
*Maximum of three (3) per family (one for employee, one for spouse and one for all eligible children combined). The following do not apply to out-of-pocket maximum: Non-covered items. Out-of-pocket maximums are accumulated separately for in-network and out-of-network services.		
Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Office Visits: Preventive Care		
Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.		
• Well-child care, immunizations	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 60% after deductible (<i>deductible waived through age 5</i>)
• Periodic health examinations	Plan pays 100% (<i>not subject to deductible</i>)	Not covered
• Annual gynecology examination	Plan pays 100% (<i>not subject to deductible</i>)	Not covered
• Prostate screening	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 60% after deductible
Illness or Injury		
• Physician office visit (includes lab, radiology, and office surgery)	\$25 copayment	Plan pays 60% after deductible
• Physician after hours office visit	\$30 copayment	Plan pays 60% after deductible
• Specialty care physician office visit	\$40 copayment	Plan pays 60% after deductible
• Second surgical opinion	\$40 copayment	Plan pays 60% after deductible
• Allergy care (office visit, testing, serum, and allergy shots)	\$25 Physician copayment or \$40 Specialist Physician copayment	Plan pays 60% after deductible
• Maternity physician services (prenatal, delivery, postpartum)	\$100 copayment (<i>first office visit only</i>)	Plan pays 60% after deductible
• Telehealth Services – Online Physician Visit	\$25 copayment	Plan pays 60% after deductible
• Services provided by network dermatologists	\$40 copayment	Plan pays 60% after deductible
Emergency Room Services		
• Life-threatening illness or serious accidental injury	\$200 copayment (<i>waived if admitted</i>)	\$200 copayment (<i>waived if admitted</i>)
• Non-emergency use of the emergency room	Not covered	Not covered
Inpatient Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Plan pays 80% after deductible	Plan pays 60% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible	Plan pays 60% after deductible

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Outpatient Services		
• Surgery facility/hospital charges	Plan pays 80% after deductible	Plan pays 60% after deductible
• Diagnostic x-ray and lab services	Plan pays 80% after deductible	Plan pays 60% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible	Plan pays 60% after deductible
Therapy Services Calendar year maximums are combined between in-network and out-of-network.		
• Speech Therapy	\$40 copayment; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
• Physical, Occupational Therapy	\$40 copayment; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
• Respiratory Therapy	Plan pays 100% after deductible; 30-visit calendar year maximum	Plan pays 60% after deductible; 30-visit calendar year maximum
• Radiation Therapy, Chemotherapy	Plan pays 100% after deductible	Plan pays 60% after deductible
Mental Health/Substance Abuse Services Services must be authorized by calling 1-800-292-2879.		
• Inpatient (facility and physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Inpatient Substance Abuse Detoxification (facility and physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Partial Hospitalization Program (facility and physician fee)	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 60% after deductible
• Intensive Outpatient Program (facility and physician fee)	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 60% after deductible
▪ Office mental health and substance abuse services (physician fee)	\$25 copayment	Plan pays 60% after deductible
▪ Outpatient mental health and substance abuse services (physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
Other Services Calendar year maximums are combined between in-network and out-of-network.		
• Urgent Care Center	\$60 copayment	\$60 copayment; plan pays 60% after copayment and deductible
• Skilled Nursing Facility	Plan pays 100% after deductible; 30-day calendar year maximum	Plan pays 60% after deductible; 30-day calendar year maximum
• Home Health Care	Plan pays 100% after deductible; 120-visit calendar year maximum	Plan pays 60% after deductible; 120-visit calendar year maximum
• Hospice Care	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 100% (<i>not subject to deductible</i>)
• Ambulance (when medically necessary)	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 100% (<i>not subject to deductible</i>)
Prescription Drugs		
To receive maximum coverage, have your prescriptions written by a network physician and filled at one of the pharmacies in our network. These include certain local independent pharmacies, as well as many national chain pharmacies: Bi-Lo, CVS, Ingles, Kmart, Kroger, Publix, Rite Aid, Target, Walgreens, Wal-Mart, Winn-Dixie/Save-Rite. Specialty drugs can only be obtained from a Specialty Pharmacy. Refer to last page for Tier definitions.	Unless otherwise indicated in the Certificate Booklet, each retail prescription has a 30-day supply limit and each mail order maintenance prescription has a 90-day supply limit.	
• Retail Drug - Tier 1	\$15 copayment per prescription	
• Retail Drug - Tier 2	\$30 copayment per prescription	
• Retail Drug - Tier 3	\$60 copayment per prescription	
• Home Delivery - Tier 1	\$30 copayment per prescription	
• Home Delivery - Tier 2	\$60 copayment per prescription	
• Home Delivery - Tier 3	\$120 copayment per prescription	

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

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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.

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:

- 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 extraction of impacted teeth
- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- 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 Form # F-1681.772* (the contract) for a complete explanation of covered services, limitations and exclusions.



The Power of BlueSM

3350 Peachtree Road, NE • Atlanta, Georgia 30326 • 1-900-441-2273

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.

eff 10/1/10 (HCR & FMHP updates)
Custom Summary (Original Plan 5200AX)-revised 9/14/2015