Mission Health of Georgia-DRAFT
Blue Open Access NS POS 5K/70 Benefit Summary

All benefits are subject to the benefit period 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.
Visit and day limit accumulation begins after the deductible is satisfied.

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

Deductibles, Coinsurance and Maximums	In-network Benefit Level	Out-of-Network Benefit Level
Benefit Period Deductible*		
▪ Individual	$5,000	$10,000
▪ Family	$10,000	$20,000
Coinsurance	Member pays 30% Plan pays 70%	Member pays 40% Plan pays 60%
Benefit Period Out-of-Pocket Maximum* (includes benefit period deductible)		
▪ Individual	$6,350	$26,000
▪ Family	$12,700	$52,000
Lifetime Maximum	Unlimited	Unlimited

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

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

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Office Surgery (surgery and administration of general anesthesia)	Member pays 30% after deductible	Member pays 40% after deductible
Office Therapy Services ▪ Physical Therapy and Occupational Therapy: 20-visit benefit period maximum combined ▪ Speech Therapy: 20-visit benefit period maximum ▪ Chiropractic Care/Manipulation Therapy: 20-visit benefit period maximum (All benefit period maximums are combined between in-network and out-of-network)	$50 copayment	Member pays 40% after deductible
Other Therapy Services (chemotherapy, radiation therapy, cardiac rehabilitation [no visit limitations per benefit period] and respiratory/pulmonary therapy)	Member pays 30% after deductible	Member pays 40% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 30% 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	$300 copayment; then member pays 30%	$300 copayment; then member pays 30%
Outpatient Facility Services ▪ Surgery facility/hospital charges ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 30% 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 30% after deductible	Member pays 40% after deductible
Skilled Nursing Facility ▪ 150-day benefit period maximum	Member pays 30% 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 30% after deductible	Member pays 40% after deductible
▪ Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)* (facility and physician fee)	Member pays 30% after deductible	Member pays 40% after deductible
▪ Office/Outpatient mental health and substance abuse services (physician fee)	$50 copayment	Member pays 40% after deductible
Home Health Care Services ▪120-visit benefit period maximum	$50 copayment	Member pays 40% after deductible
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% (not subject to deductible)	Member pays 30% after deductible
Durable Medical Equipment (DME)	Member pays 30% after deductible	Member pays 40% after deductible
Ambulance Services (covered when medically necessary)	Member pays 30% after deductible	Member pays 30% after deductible

Prescription Drugs (Option A) Note: If a member receives a brand name drug that falls on Tier 3 that has a generic equivalent available, the member pays the Tier 1 copay, plus the difference in cost between the brand drug and generic drug. This applies even when physician indicates DAW (dispense as written).	
Retail and Home Delivery maintenance drug coverage is provided at one of four tier levels in accordance with the Formulary Drug List. Members must file a claim form for reimbursement when using an out-of-network pharmacy. Specialty drugs can only be obtained from a Specialty Pharmacy. Refer to last page for Tier definitions	
▪ Retail Drugs – Tier 1 (30 day supply)	$20 copayment
▪ Retail Drugs – Tier 2 (30 day supply)	$50 copayment
▪ Retail Drugs – Tier 3 (30 day supply)	$80 copayment
▪ Retail Drugs – Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	$40 copayment
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	$100 copayment
▪ Home Delivery Maintenance Drugs - Tier 3 (90 day supply)	$160 copayment
▪ Home Delivery Maintenance Drugs – Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period

Your benefit period is a calendar year meaning your benefit period runs from January through December.

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 Form# WGAPOS-001, 01012012* (the contract) for a complete explanation of covered services, limitations and exclusions.

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

BlueCross BlueShield Healthcare Plan of Georgia

The Power of Blue℠

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