BlueCross BlueShield of Georgia

PPO Summary of Benefits

www.bcbsga.com

Plan 410

BlueChoice PPO Benefit Summary

	In-Network Benefit Level	Out-of-Network Benefit Level
Deductibles, Maximums, Etc.		
• Deductible: one deductible for employee, one for spouse, one for all children combined		
– Individual (combined in- and out-of-network)	• $300	• $300
– Family (combined in- and out-of-network)	• $900	• $900
• Coinsurance: the percentage of eligible charges for which you are responsible	• Plan pays 80% after deductible	• Plan pays 60% after deductible
• Out-of-Pocket Calendar Year Maximum		
– Individual (excludes deductible)	• $2,000	• $4,000
– Family (excludes deductible)	• $6,000	• $12,000
• Lifetime Maximum (combined in- and out-of-network)	• $2,000,000	• $2,000,000
Office Visits		
Preventive Health Care		
• Well-child care, immunizations	• $10 copayment	• Plan pays 60%, annual deductible waived for well child care through age 5
• Periodic health examinations	• $10 copayment	• Not covered
• Annual gynecology examination	• $20 copayment	• Plan pays 60% after deductible for annual Pap
• Mammogram	• $20 copayment	• Plan pays 60% after deductible
• Prostate screening	• $10 copayment	• Plan pays 60% after deductible for annual exam
Illness or Injury		
• Primary care physician (PCP) office visit (including diagnostic X-rays and laboratory performed in physician's office)	• $10 copayment	• Plan pays 60% after deductible
• Specialty care physician office visit	• $20 copayment	• Plan pays 60% after deductible
• Second surgical opinion	• $20 copayment	• Plan pays 60% after deductible
• Surgery in physician's office	• Plan pays 80% after deductible	• Plan pays 60% after deductible
• Allergy care including:		
– Physician office visit	• $10 copayment	• Plan pays 60% after deductible
– Allergy testing, shots, and serum	• Plan pays 80% after deductible	• Plan pays 60% after deductible
• Maternity services (prenatal/delivery/ postpartum)	• All physician charges related to prenatal, delivery and post-partum care are covered by $100 copayment at first office visit	• Plan pays 60% after deductible
Emergency Room Services		
• Life-threatening illness, serious accidental injury	• $100 copayment, waived if admitted	• $100 copayment, waived if admitted
• Non-emergency use of the emergency room	• Plan pays 80% after $100 copayment and annual deductible	• Plan pays 60% after $100 copayment and annual deductible
Inpatient 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	• Plan pays 80% after deductible	• Plan pays 60% after deductible
• Physician services (surgery, anesthesia, radiology, pathology, etc.)	• Plan pays 80% after deductible	• Plan pays 60% after deductible

	In-Network Benefit Level	Out-of-Network Benefit Level
Outpatient Services		
• Facility/hospital charges (including diagnostic X-ray and lab services)	• Plan pays 80% after deductible	• Plan pays 60% after deductible
• Physician services (surgery, anesthesia, radiology, pathology, etc.)	• Plan pays 80% after deductible	• Plan pays 60% after deductible
• Therapy services:	**Annual visit limits are combined between in-network and out-of-network**	
– Speech therapy	• Plan pays 80% after deductible; 20-visit calendar year maximum	• Plan pays 60% after deductible; 20-visit calendar year maximum
– Physical, occupational therapy	• Plan pays 80% after deductible; 30-visit calendar year maximum	• Plan pays 60% after deductible; 30-visit calendar year maximum
– Respiratory therapy	• Plan pays 80% after deductible; 30-visit calendar year maximum	• Plan pays 60% after deductible; 30-visit calendar year maximum
– Radiation therapy and chemotherapy	• Plan pays 80% after deductible	• Plan pays 60% after deductible
Mental Health/Substance Abuse Services	**Annual inpatient day and outpatient visit limits are combined between in-network and out-of-network**	
• Inpatient (facility and physician fee)	• Plan pays 80% after deductible; 30-day calendar year maximum	• Plan pays 60% after deductible; 30-day calendar year maximum
• Outpatient	• Plan pays 80% after deductible; 20-visit calendar year maximum	• Plan pays 60% after deductible; 20-visit calendar year maximum
• Inpatient alcohol or substance abuse detoxification	• Plan pays 80% after deductible; 6-day calendar year maximum (combined with other inpatient mental health and substance abuse benefits)	• Plan pays 60% after deductible; 6-day calendar year maximum (combined with other inpatient mental health and substance abuse benefits)
Other Services	**Calendar year benefits, annual visit limits and lifetime maximums are combined between in-network and out-of-network**	
• Skilled nursing facility	• Plan pays 80% after deductible; 30-days per calendar year	• Plan pays 60% after deductible; 30-days per calendar year
• Private duty nursing (RN and LPNs)	• Plan pays 80% after deductible; $2,500 benefit per calendar year	• Plan pays 60% after deductible; $2,500 benefit per calendar year
• Temporomandibular Joint Dysfunction (TMJ)	• Plan pays 80% after deductible; $15,000 lifetime maximum	• Plan pays 60% after deductible; $15,000 lifetime maximum
• Home health care	• $20 copayment per visit; 120-visit annual maximum	• Plan pays 60% after deductible; 120-visit annual maximum
• Hospice care	• Plan pays 100%; $10,000 lifetime maximum	• Plan pays 100%; $10,000 lifetime maximum
• Ambulance	• Plan pays 100% when medically necessary	• Plan pays 100% when medically necessary
Prescription Drugs		**Member must file claim for reimbursement**
• Drug coverage is provided at one of three copayment benefit levels in accordance with the Preferred Drug Formulary when drugs are purchased at a participating or non-participating pharmacy (see last page of this summary for more information)	• $15 copayment for a formulary generic drug • $30 copayment for a formulary brand name drug • $60 copayment for a non-formulary drug	• $15 copayment for a formulary generic drug • $30 copayment for a formulary brand name drug • $60 copayment for a non-formulary drug

In-Network versus Out-of-Network Services

As a BlueChoice PPO member, you have the ability to receive services either from providers in the BlueChoice PPO network or outside this network. Generally, you will pay less out of your own pocket if you elect in-network services.

- ***In-Network Services*** are those services provided by doctors, hospitals and other providers listed in your BlueChoice PPO directory.
- ***Out-of-Network Services*** are, except in the case of an emergency (see below) those services provided by a provider not listed in the *Provider Directory*. For services outside the network, you will be responsible for satisfying an annual deductible, after which you will pay a percentage of the total charge called coinsurance.

Pre-Existing Condition Limitation and Credit for Prior Coverage

Until a member has had "creditable coverage" for 12 consecutive months, benefits for service shall not be available for any illness, injury or condition for which medical advice or treatment was recommended by, or received from, a health care provider within six months preceding the effective date of coverage (excepting maternity services, for which the pre-existing condition limitation is not applicable).

Emergencies

If you have a medical emergency, call 911 or proceed immediately to the nearest hospital emergency room. A "medical emergency" is defined as, "a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in their health being in serious jeopardy, serious impairment to bodily functions, or serious dysfunctions of any bodily organ."

Prescription Drugs

- ***Participating Pharmacies.*** BlueChoice PPO offers prescription drug coverage through a pharmacy network that has contracted and agreed to participate with Blue Cross and Blue Shield of Georgia and to electronically file claims directly to us for your convenience.
- ***Non-Participating Pharmacies.*** If you choose to have your prescription filled at a non-participating pharmacy, you will be responsible for filing the claim with Blue Cross and Blue Shield of Georgia for reimbursement. Additionally, if the amount you paid is greater than the amount BlueChoice PPO would have paid our participating pharmacy, you will be responsible for that difference.
- ***Coverage*** is provided in accordance with our preferred drug benefit. To receive a copy of our Preferred Drug Benefit Guide, please call customer service at 1-800-441-2273.

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
- Surgical or medical care for: artificial insemination, in-vitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood
- Smoking cessation products

Prior Authorization

For in-network services, your doctor and/or hospital will be responsible for ensuring that any surgical procedure or inpatient admissions must obtain the necessary prior authorization. For out-of-network services, you should be sure that Blue Cross and Blue Shield of Georgia has authorized home health care services and inpatient care (excluding maternity related care) prior to these services being rendered.

NOTE: Services that require prior authorization are subject to change.

Additional Information

Should you need additional information, the best sources are your *Provider Directory/Member Guide* and your *Certificate Booklet*. You may also visit our web site at www.bcbsga.com for more information. If you have specific questions that require an answer from our representatives, please call customer service at **1-800-441-2273.**

BlueCard PPO

If you need medical treatment when traveling, you have access to the largest PPO network in the country – the nationwide network of Blue Cross Blue Shield plans. Through the BlueCard PPO program, you may obtain services from a PPO participating provider in any participating state and receive the same benefits you would at home. For a listing of participating providers in a particular area, please call 1-800-810-BLUE.

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-1681.792 (the contract) for a complete explanation of covered services, limitations and exclusions.

Blue Cross and Blue Shield of Georgia • 3350 Peachtree Road, NE • Atlanta, Georgia 30326 • 1-800-441-2273

Underwritten by Blue Cross Blue Shield of Georgia, an Independent Licensee of the Blue Cross Blue Shield Association
® Registered Mark of the Blue Cross Blue Shield Association

0008403-1102