



# BlueChoice HMO - Large Group (51+ Employees) Plan 6500SX Benefit Summary

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.

Deductibles, Coinsurance and Maximums	In-Network Benefit Level No Coverage for Out-of-Network
Calendar Year Deductible: <i>one deductible for employee, one for spouse, one for all eligible children combined</i> <ul style="list-style-type: none"> <li>- Individual</li> <li>- Family</li> </ul>	\$1,000 \$3,000
Coinsurance	Plan pays 80% after deductible Member pays 20% after deductible
Lifetime Maximum	Unlimited
Out-of-Pocket Calendar Year Maximum* <ul style="list-style-type: none"> <li>- Individual</li> <li>- Family</li> </ul>	\$2,000 \$6,000
*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 maximums: deductibles, copayment amounts, non-emergency room copayments and non-covered items.	
Covered Services	In-Network Benefit Level
<b>Office Visits: Preventive Care</b>	
• Well-child care, immunizations	\$40 copayment
• Periodic health examinations	\$40 copayment
• Annual gynecology examination (No PCP referral required)	\$40 copayment
• Prostate screening	\$40 copayment
<b>Illness or Injury</b>	
• Primary Care Physician (PCP) office visit (includes lab, radiology and office surgery)	\$40 copayment
• Primary care physician after hours office visit	\$45 copayment
• Specialty care physician office visit (PCP referral required)	\$40 copayment
• Second surgical opinion (PCP referral required)	\$40 copayment
• Maternity physician services (prenatal, delivery, postpartum)	\$500 copayment ( <i>first office visit only</i> )
• Allergy care (office visit, testing, serum and allergy shots)	\$40 copayment
• Vision care services provided by network ophthalmologist or optometrist for the treatment of acute conditions (No PCP referral required)	\$40 copayment
• Services provided by a network dermatologist (No PCP referral required)	\$40 copayment
<b>Emergency Room Services</b>	
• Life-threatening illness, serious accidental injury or with a PCP referral	\$150 copayment ( <i>waived if admitted</i> )
• Non-emergency use of the emergency room	Not covered
<b>Inpatient Services</b>	
• 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	\$500 copayment; plan pays 80% after copayment
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible

Covered Services	In-Network Benefit Level
<b>Outpatient Services</b>	
• Surgery facility/hospital charges	\$500 copayment, plan pays 80% after copayment
• Diagnostic x-ray and lab services	Plan pays 80% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible
<b>Therapy Services</b>	
• Speech Therapy	\$40 copayment; 20-visit calendar year maximum
• Physical, Occupational Therapy	\$40 copayment; 20-visit calendar year maximum
• Respiratory Therapy	Plan pays 100% after deductible; 30-visit calendar year maximum
• Radiation Therapy, Chemotherapy	Plan pays 100% after deductible
<b>Mental Health/Substance Abuse Services</b> No Primary Care Physician referral required. Services must be authorized by calling 1-800-292-2879.	
• Inpatient (facility fee)	\$500 copayment, plan pays 80% after copayment
• Inpatient (physician fee)	Plan pays 80% after deductible
• Inpatient Substance Abuse Detoxification (facility fee)	\$500 copayment, plan pays 80% after copayment
• Inpatient Substance Abuse Detoxification (physician fee)	Plan pays 80% after deductible
• Partial Hospitalization Program (facility and physician fee)	Plan pays 80% after deductible
• Intensive Outpatient Program (facility and physician fee)	Plan pays 80% after deductible
• Professional Outpatient Services	\$40 copayment
<b>Other Services</b>	
• Urgent Care Center	\$60 copayment
• Skilled Nursing Facility	Plan pays 100% after deductible; 30-day calendar year maximum
• Home Health Care	Plan pays 100% after deductible; 120-visit calendar year maximum
• Hospice Care (\$10,000 lifetime maximum)	Plan pays 100% ( <i>not subject to deductible</i> )
• Ambulance (when medically necessary)	Plan pays 100% ( <i>not subject to deductible</i> )
<b>Prescription Drugs</b>	
To receive 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 an in-network 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
• Mail-Order Maintenance Drug - Tier 1	\$60 copayment per prescription
• Mail-Order Maintenance Drug - Tier 2	\$60 copayment per prescription
• Mail-Order Maintenance Drug - Tier 3	Not Covered

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.

## Pre-Existing Condition Limitation and Credit for Prior Coverage

Under the BlueChoice Healthcare Plan, there are no pre-existing condition limitations. All in-network, covered services are eligible for benefits from your first day of coverage.

## 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
- Smoking cessation products

## 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-1681.782* (the contract) for a complete explanation of covered services, limitations and exclusions.



# *The Power of Blue*<sup>SM</sup>

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MGAEB5230GEN – eff 10/15/09 (MHPA updates)