
BlueCross BlueShield Of Georgia Medical Plan

In-Network Benefits

Out-of-Network Benefits

Calendar Year Deductible: *one for employee, one for spouse, one for all eligible children combined*

- Individual	\$1,500	\$1,500
- Family	\$4,500	\$4,500

Coinsurance;	Plan pays 80% after deductible Member pays 20% after deductible	Plan pays 60% after deductible Member pays 40% after deductible
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Lifetime Maximum:	Unlimited	\$5,000.000
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Out-of-Pocket Calendar Year Maximum*

- Individual	\$3,000	\$12,000
- Family	\$9,000	\$36,000

COVERED SERVICES

In-Network Benefits

Out-of-Network Benefits

Office Visits (Preventive Care)

• Well child care, immunizations <i>(deductible waived through age 5)</i>	\$40 copayment	60% after deductible
• Periodic health examination	\$40 copayment	Not Covered
• Annual gynecological exam <i>(Must use in-network provider for in-network benefits)</i>	\$40 PCP copay or \$50 specialist copay	60% after deductible
• Prostate Screening	\$40 PCP copay or \$50 specialist copay	60% after deductible

Illness or Injury

• Primary Care Physician (PCP) Office visit (includes lab, radiology, and office surgery)	\$40 copayment	60% after deductible
• Primary Care Physician (after hours visit)	\$45 copayment	60% after deductible
• Specialty Care Physician office visit	\$50 copayment	60% after deductible
• Second Surgical Opinion	\$50 copayment	60% after deductible
• Allergy Care (office visit, testing, serum, and allergy shots)	\$40 PCP copay or \$50 specialist copay	60% after deductible
• Maternity Physician services (prenatal, delivery, postpartum)	\$100 copayment <i>(first office visit only)</i>	60% after deductible

Illness or Injury (con't)**In-Network Benefits****Out-of-Network Benefits**

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|---|----------------|----------------------|
| • Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions | \$50 copayment | 60% after deductible |
| • Services provided by a network dermatologists | \$50 copayment | 60% after deductible |

Emergency Room Services

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|---|-----------------|-----------------|
| • Life threatening illness, serious accident injury <i>(copay waived if admitted)</i> | \$100 copayment | \$100 copayment |
| • Non-emergency use of the emergency room | Not Covered | Not Covered |

Inpatient Services

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|---|-----------------------|----------------------|
| • 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 | 80% after deductible | 60% after deductible |
| • Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 100% after deductible | 60% after deductible |

Outpatient Services

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|--|-----------------------|----------------------|
| • Surgery facility (hospital charges) | 80% after deductible | 60% after deductible |
| • Diagnostic x-ray and lab services | 80% after deductible | 60% after deductible |
| • Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 100% after deductible | 60% after deductible |

Therapy Services

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|--|-----------------------|--|
| • Speech Therapy
<i>(20 visits calendar year maximum)</i> | \$50 copayment | 60% after deductible
<i>(20 visits calendar year maximum)</i> |
| • Physical or Occupational Therapy
<i>(20 visits calendar year maximum)</i> | \$50 copayment | 60% after deductible
<i>(20 visits calendar year maximum)</i> |
| • Respiratory Therapy
<i>(30 visits calendar year maximum)</i> | 100% after deductible | 60% after deductible
<i>(30 visits calendar year maximum)</i> |
| • Radiation Therapy or Chemotherapy | 100% after deductible | 60% after deductible |

In-Network Benefits

Out-of-Network Benefits

Mental Health/ Substance Abuse Services

No Primary Care Physician referral required. Services must be authorized by calling **1-800-292-2879**

- Inpatient (facility and physician fee) 80% after deductible (30 day calendar year maximum) Not Covered
- Outpatient \$50 copayment (20 visits calendar year maximum) Not Covered
- Inpatient Substance Abuse Detoxification 80% after deductible (6 day calendar year maximum, part of the 30 days per calendar year Inpatient Behavioral Health benefit) Not Covered

Other Services

- Skilled Nursing Facility 100% after deductible (30 visits calendar year maximum) 60% after deductible (30 visits calendar year maximum)
- Home Health Care 100% after deductible (120 visits calendar year maximum) 60% after deductible (120 visits calendar year maximum) combined
- Hospice Care 100% 100% (\$10,000 lifetime maximum, not subject to deductible)
- Ambulance (when medically necessary) 100% 100%

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, Eckerd, Ingles, Kmart, Kroger. Publix, Rite Aid, Target, Walgreens, Wal-Mart, Winn-Dixie/Save-Rite.

Unless otherwise indicated in the Certificate Booklet, each prescription has a 30 day supply limit. Each mail order maintenance prescription has a 90 day supply limit.

- Generic Preferred Drug \$15 copayment 60% after deductible
- Brand Preferred Drug \$30 copayment 60% after deductible
- Non-Preferred Drug \$60 copayment 60% after deductible
- Mail Order Maintenance Drug \$60 copayment (excludes non-preferred) (per prescription) Not Available

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

Bi-Weekly Premium - Low Option

**Employee Only - Paid by Rabun County
Family Coverage - \$90 per pay period**

PRE-EXISTING CONDITION LIMITATION AND CREDIT FOR PRIOR COVERAGE

For in-network services, there is no pre-existing condition limitation. For out-of-network services, benefits are not available during a pre-existing limitation period for services 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. *The pre-existing limitation period may be reduced or eliminated by the submission of a certificate of prior creditable coverage.* The pre-existing limitation period does not apply to maternity services.

SUMMARY OF LIMITATIONS AND EXCLUSIONS

Your Certificate Booklet will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed as follows:

- 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.

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-1681A.722 (the contract) for a complete explanation of covered services, limitations and exclusions.

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Underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia, and Independent Licensee of the Blue Cross Blue Shield Association

