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## BlueCross BlueShield Of Georgia Medical Plan - High Option

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### In-Network Benefits

### Out-of-Network Benefits

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

- Individual	\$500	\$1,000
- Family	\$1,500	\$3,000

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

- Individual	\$1,000	\$4,000
- Family	\$3,000	\$12,000

### **COVERED SERVICES**

#### In-Network Benefits

#### Out-of-Network Benefits

#### **Office Visits (Preventive Care)**

- |                                                                                                  |                                            |                      |
|--------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------|
| • Well child care, immunizations<br><i>(deductible waived through age 5)</i>                     | \$25 copayment                             | 60% after deductible |
| • Periodic health examination                                                                    | \$25 copayment                             | 60% after deductible |
| • Annual gynecological exam<br><i>(Must use in-network provider<br/>for in-network benefits)</i> | \$25 PCP copay or<br>\$35 specialist copay | 60% after deductible |
| • Prostate Screening                                                                             | \$25 PCP copay or<br>\$35 specialist copay | 60% after deductible |

#### **Illness or Injury**

- |                                                                                                 |                                                     |                      |
|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------|
| • Primary Care Physician (PCP)<br>Office visit (includes lab, radiology,<br>and office surgery) | \$25 copayment                                      | 60% after deductible |
| • Primary Care Physician<br>(after hours visit)                                                 | \$30 copayment                                      | 60% after deductible |
| • Specialty Care Physician<br>office visit                                                      | \$35 copayment                                      | 60% after deductible |
| • Second Surgical Opinion                                                                       | \$35 copayment                                      | 60% after deductible |
| • Allergy Care (office visit,<br>testing, serum, and allergy<br>shots)                          | \$25 PCP copay or<br>\$35 specialist copay          | 60% after deductible |
| • Maternity Physician services<br>(prenatal, delivery, postpartum)                              | \$100 copayment<br><i>(first office visit only)</i> | 60% after deductible |

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

- |                                                                                                               |                |                      |
|---------------------------------------------------------------------------------------------------------------|----------------|----------------------|
| • Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions | \$35 copayment | 60% after deductible |
| • Services provided by a network dermatologists                                                               | \$35 copayment | 60% after deductible |

**Emergency Room Services**

- |                                                                                       |                 |                 |
|---------------------------------------------------------------------------------------|-----------------|-----------------|
| • 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**

- |                                                                                                                                                                                             |                       |                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------|
| • 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**

- |                                                                                  |                       |                      |
|----------------------------------------------------------------------------------|-----------------------|----------------------|
| • 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**

- |                                                                                |                       |                                                                  |
|--------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------|
| • Speech Therapy<br><i>(20 visits calendar year maximum)</i>                   | \$35 copayment        | 60% after deductible<br><i>(20 visits calendar year maximum)</i> |
| • Physical or Occupational Therapy<br><i>(20 visits calendar year maximum)</i> | \$35 copayment        | 60% after deductible<br><i>(20 visits calendar year maximum)</i> |
| • Respiratory Therapy<br><i>(30 visits calendar year maximum)</i>              | 100% after deductible | 60% after deductible<br><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)
- Outpatient
- Inpatient Substance Abuse Detoxification

80% after deductible  
*(30 day calendar year maximum)*

\$35 copayment  
*(20 visits calendar year maximum)*

80% after deductible  
*(6 day calendar year maximum, part of the 30 days per calendar year Inpatient Behavioral Health benefit )*

Not Covered

Not Covered

Not Covered

**Other Services**

- Skilled Nursing Facility
- Home Health Care  
*(In and out of network combined)*
- Hospice Care  
*(\$10,000 lifetime maximum, not subject to deductible)*
- Ambulance *(when medically necessary)*

100% after deductible  
*(30 visits calendar year maximum)*

100% after deductible  
*(120 visits calendar year maximum)*

100%

100%

60% after deductible  
*(30 visits calendar year maximum)*

60% after deductible  
*(120 visits calendar year maximum)*

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<br><i>(excludes non-preferred)</i> | \$60 copayment<br><i>(per prescription)</i> | Not Available        |

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

**Bi-Weekly Premium - High Option**

**Employee Only - \$35 per pay period**  
**Family Coverage - \$200 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.

**Blue Cross Blue Shield Healthcare Plan of Georgia**  
**3350 Peachtree Road, NE**  
**Atlanta, Georgia 30326**  
**1-800-441-2273**

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



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## BlueCross BlueShield Of Georgia Medical Plan - Low Option

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### 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

<b>Coinsurance;</b>	Plan pays 80% after deductible Member pays 20% after deductible	Plan pays 60% after deductible Member pays 40% after deductible
---------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------

<b>Lifetime Maximum:</b>	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**

- |                                                                                                               |                |                      |
|---------------------------------------------------------------------------------------------------------------|----------------|----------------------|
| • 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**

- |                                                                                       |                 |                 |
|---------------------------------------------------------------------------------------|-----------------|-----------------|
| • 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**

- |                                                                                                                                                                                             |                       |                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------|
| • 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**

- |                                                                                  |                       |                      |
|----------------------------------------------------------------------------------|-----------------------|----------------------|
| • 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**

- |                                                                                |                       |                                                                  |
|--------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------|
| • Speech Therapy<br><i>(20 visits calendar year maximum)</i>                   | \$50 copayment        | 60% after deductible<br><i>(20 visits calendar year maximum)</i> |
| • Physical or Occupational Therapy<br><i>(20 visits calendar year maximum)</i> | \$50 copayment        | 60% after deductible<br><i>(20 visits calendar year maximum)</i> |
| • Respiratory Therapy<br><i>(30 visits calendar year maximum)</i>              | 100% after deductible | 60% after deductible<br><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 <i>(30 day calendar year maximum)</i>	Not Covered
• Outpatient	\$50 copayment <i>(20 visits calendar year maximum)</i>	Not Covered
• Inpatient Substance Abuse Detoxification	80% after deductible <i>(6 day calendar year maximum, part of the 30 days per calendar year Inpatient Behavioral Health benefit )</i>	Not Covered

**Other Services**

• Skilled Nursing Facility	100% after deductible <i>(30 visits calendar year maximum)</i>	60% after deductible <i>(30 visits calendar year maximum)</i>
• Home Health Care <i>(In and out of network combined)</i>	100% after deductible <i>(120 visits calendar year maximum)</i>	60% after deductible <i>(120 visits calendar year maximum)</i>
• Hospice Care <i>(\$10,000 lifetime maximum, not subject to deductible)</i>	100%	100%
• Ambulance <i>(when medically necessary)</i>	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 <i>(excludes non-preferred)</i>	\$60 copayment <i>(per prescription)</i>	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.

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- 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.

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