

# Fayette County BOC



## POS Summary of Benefits

## BlueChoice Option (POS) Benefit Summary

In-Network Benefit Level

Out-of-Network Benefit Level

### Deductibles, Maximums, Etc.

<ul style="list-style-type: none"> <li>• Deductible: one deductible for employee, one for spouse, one for all children combined                             <ul style="list-style-type: none"> <li>- Individual</li> <li>- Family</li> </ul> </li> <li>• Coinsurance: the percentage of eligible charges for which you are responsible</li> <li>• Out-of-Pocket Calendar Year Maximum                             <ul style="list-style-type: none"> <li>- Individual (excludes deductible)</li> <li>- Family (excludes deductible)</li> </ul> </li> <li>• Lifetime Maximum</li> </ul>	<ul style="list-style-type: none"> <li>• \$0</li> <li>• \$0</li> <li>• Plan pays 90%</li> <li>• \$1,000</li> <li>• \$3,000</li> <li>• Unlimited</li> </ul>	<ul style="list-style-type: none"> <li>• \$300</li> <li>• \$900</li> <li>• Plan pays 70%</li> <li>• \$3,000</li> <li>• \$9,000</li> <li>• \$2,000,000</li> </ul>
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### Office Visits

#### Preventive Health Care

<ul style="list-style-type: none"> <li>• Well-child care, immunizations</li> <li>• Periodic health examinations</li> <li>• Annual gynecology examination (No PCP referral required - Must use network provider for in-network benefits)</li> <li>• Prostate screening</li> </ul>	<ul style="list-style-type: none"> <li>• \$15 copayment</li> <li>• \$15 copayment</li> <li>• \$25 copayment</li> <li>• \$15 copayment</li> </ul>	<ul style="list-style-type: none"> <li>• Plan pays 70%; annual deductible waived for well child care through age 5</li> <li>• Not covered</li> <li>• Plan pays 70% after deductible for annual Pap and mammogram</li> <li>• Plan pays 70% after deductible for annual exam</li> </ul>
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#### Illness or Injury

<ul style="list-style-type: none"> <li>• Primary care physician (PCP) office visit (includes lab, radiology and office surgery)</li> <li>• Primary care physician after hours office visit</li> <li>• Specialty care physician office visit (PCP referral required)</li> <li>• Second surgical opinion (PCP referral required)</li> <li>• Allergy care (Primary care physician office visit, specialty care, allergy shots, serum and testing)</li> <li>• Maternity services (prenatal/delivery/postpartum)</li> <li>• Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions (No PCP referral required)</li> <li>• Services provided by network dermatologists (No PCP referral required)</li> </ul>	<ul style="list-style-type: none"> <li>• \$15 copayment</li> <li>• \$15 copayment</li> <li>• \$25 copayment</li> <li>• \$25 copayment</li> <li>• \$15 PCP copayment</li> <li>• \$25 specialist copayment</li> <li>• All physician charges related to prenatal, delivery and postpartum care are covered by \$20 copayment at first office visit</li> <li>• \$25 copayment</li> <li>• \$25 copayment</li> </ul>	<ul style="list-style-type: none"> <li>• Plan pays 70% after deductible</li> </ul>
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### Inpatient Services

<ul style="list-style-type: none"> <li>• 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</li> <li>• Physician services (surgery, anesthesia, radiology, pathology, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Plan pays 90%</li> <li>• Plan pays 100%</li> </ul>	<ul style="list-style-type: none"> <li>• Plan pays 70% after deductible</li> <li>• Plan pays 70% after deductible</li> </ul>
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**In-Network Benefit Level****Out-of-Network Benefit Level****Outpatient Services**

- Facility/hospital charges (including diagnostic x-ray and lab services)
- Outpatient surgery outside physician's office (facility component only)
- Physician services (surgery, anesthesia, radiology, pathology, etc.)
- Therapy services:
  - Speech therapy
  - Physical, occupational therapy
  - Respiratory therapy
  - Radiation therapy, chemotherapy

- Plan pays 90%
- Plan pays 90%
- Plan pays 100%

- Plan pays 70% after deductible
- Plan pays 70% after deductible
- Plan pays 70% after deductible

**Annual visit limits are combined between in-network and out-of-network**

- \$25 copayment; 20-visit calendar year maximum
- \$25 copayment; 20-visit calendar year maximum
- Plan pays 100%; 40-visit calendar year maximum
- Plan pays 100%
- Plan pays 70% after deductible; 20-visit calendar year maximum
- Plan pays 70% after deductible; 20-visit calendar year maximum (includes Chiropractic care)
- Plan pays 70% after deductible; 40-visit calendar year maximum
- Plan pays 70% after deductible

**Emergency Room Services**

- Life-threatening illness, serious accidental injury or with a PCP referral
- Non-emergency use of the emergency room

- \$100 copayment, waived if admitted
- Not covered

- \$100 copayment, waived if admitted
- Not covered

**Mental Health/Substance Abuse Services (Provided through Blue Cross Blue Shield of Georgia )**

**No PCP referral required. Services must be authorized by Blue Cross Blue Shield of Georgia at 1-800-292-2879. Annual inpatient day and outpatient visit limits are combined**

- Inpatient (facility and physician fee)
- Outpatient
- Inpatient alcohol or substance abuse detoxification

- Plan pays 90%; 30-day calendar year maximum
- \$25 copayment; 20-visit calendar year maximum
- Plan pays 90%; 6-day calendar year maximum (combined with other inpatient mental health and substance abuse benefits)

- Not covered
- Not covered
- Not covered

**Other Services**

- Skilled nursing facility
- Home health care
- Hospice care
- Ambulance

**Annual maximum is combined between in-network and out-of-network**

- Plan pays 100%; 30-day calendar year maximum
- Plan pays 100%; 120-visit annual maximum
- Plan pays 100%; \$15,000 lifetime maximum
- Plan pays 100% when medically necessary

- Plan pays 70% after deductible; 30-day calendar year maximum
- Plan pays 70% after deductible; 120-visit calendar year maximum
- Plan pays 100%; \$15,000 lifetime maximum
- Plan pays 100% when medically necessary

**Prescription Drugs**

Prescriptions must be written by a network physician or an emergency room physician

- Participating pharmacies include: Bi-Lo, CVS, Drug Emporium, Eckerd, Kmart, Kroger, Publix, Walgreens, WalMart, Winn-Dixie, and many independent pharmacies

- \$5 copayment for formulary generic (up to 30-day supply)
- \$25 copayment for formulary name brands (up to 30-day supply)
- \$40 copayment for a non-formulary drug (up to 30-day supply)

- \$5 copayment for formulary generic (up to 30-day supply)
- \$25 copayment for formulary name brands (up to 30-day supply)
- \$40 copayment for a non-formulary drug (up to 30-day supply)

- Mail order maintenance drugs

- 2x-retail copay (up to 90day supply)
- 2x-retail copay (up to 90day supply)

### Primary Care Physician

A primary care physician, or PCP, is a doctor who specializes in family or general practice, internal medicine or pediatrics and participates in the BlueChoice Option network. Each BlueChoice Option member must select a PCP. Your PCP is responsible for providing or coordinating necessary care for you 24 hours per day, 7 days a week. For additional medical information call BlueChoice On-Call, available 24 hours per day, 7 days a week.

### In-Network versus Out-of-Network Services

As a BlueChoice Option member, you have the ability to receive services either from providers in the BlueChoice Option 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 that are either provided or coordinated by your PCP. Some services do not require PCP coordination. Please keep in mind that even though a referral is not required for certain services, you must select a provider from the network directory to receive in-network benefits. Services that do not require a PCP referral include:
  - ❑ **OB/GYN** services for the treatment of an obstetrical or gynecological-related condition
  - ❑ **Covered Vision Care Services** - from a network ophthalmologist or optometrist (Routine vision services may not be covered under your policy - if you do not know if you have routine vision coverage, please call customer service at 1-800-441-2273).
  - ❑ **Dermatological care** for skin-related conditions
  - ❑ **Mental Health or Substance Abuse benefits** - You may contact Magellan Behavioral Health directly at 1-800-292-2879 without contacting your PCP.
- **Out-of-Network Services** are those services that your PCP did not coordinate. 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

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.

### 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

BlueChoice Option offers prescription drug coverage through a pharmacy network that includes many national pharmacy chains and select local pharmacies. Coverage is provided according to our preferred drug formulary for prescriptions written by a network physician and filled at a network pharmacy. Out-of-network prescriptions are also subject to the preferred drug formulary. We have included in the *Prescription Drug Program* section of the *Provider Directory/Member Guide* a listing of some of the most commonly

used drugs along with a notation of whether they are covered or non-covered. If you have specific questions about this benefit, please contact 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

Your PCP must coordinate most in-network services. For in-network services, your PCP (or the specialist to whom you were referred by your PCP) will be responsible for ensuring that any surgical procedures or inpatient admissions obtain the necessary prior authorization. For out-of-network services, you should be sure that Blue Cross Blue Shield Healthcare Plan of Georgia has authorized the following procedures prior to these services being rendered:

- Home health care services
- All outpatient surgery, including laproscopic and arthroscopic procedures
- Durable Medical Equipment over \$250
- MRIs
- EMGs
- All scopes, including endoscopy and colonoscopy
- Myelography
- Cardiac catheterization

**NOTE: This list is subject to change.**

If you receive out-of-network treatment and prior authorization was not obtained, all charges will be denied. You, the member, will be responsible for all charges.

### 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](http://www.bcbsga.com) for more information. If you have specific questions that require an answer from our representatives, please call one of the following numbers:

- Customer Service..... 1-800-441-2273
- Magellan Behavioral Health (Mental Health/ Substance Abuse Services)..... 1-800-292-2879
- Mail Order Prescriptions ..... 1-800-441-2273
- BlueChoice On-Call ..... 1-888-724-2583

### 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-1681.772* (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

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