Healthy Support Open Access POS – Large Groups
OAP2H 5K/30 6.6K P1 Benefit Summary

All benefits are subject to the calendar year deductible, except those with in-network home/office visit copayments, emergency room services and urgent care center services, unless otherwise noted.
All calendar year maximums are combined between in-network and out-of-network.
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.

When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles and/or applicable coinsurance.

Deductibles, Coinsurance and Maximums	In-network Benefit Level	Out-of-Network Benefit Level
Calendar Year Deductible* ▪ Individual ▪ Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance	Member pays 30% Plan pays 70%	Member pays 40% Plan pays 60%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible) ▪ Individual ▪ Family	 $6,600 $13,200	 $19,800 $39,600
Lifetime Maximum	Unlimited	Unlimited
*Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member's deductible amount also goes toward the Family deductible and out-of-pocket maximum. Not everyone has to meet his or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses. The following do not apply to out-of-pocket maximums: non-covered items, plan premiums, any balance billing due to Out-of-Network services. The medical copayments on this plan will apply toward the out-of-pocket maximums.		

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Preventive Care Services for Children and Adults (preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits) ▪ Well-child care, immunizations ▪ Periodic health examinations ▪ Annual gynecology examinations ▪ Prostate screenings	Member pays 0% (not subject to deductible)	Member pays 30% after deductible (deductible waived through age 5)
Illness or Injury * Home and/or office visits are limited to a combined 3-visit copayment maximum. For all copay visits after the 3th visit, the member pays 30% after deductible.		
Physician Office Visits for Illness and Injury ▪ Primary Care Physician (PCP)[1] ▪ Specialist Physician [1]Also applies to services rendered at Retail Health Clinics	$35 copayment*	Member pays 40% after deductible
Maternity Physician Services ▪ Global obstetrical care (prenatal, delivery and postpartum services)	Member pays 30% after deductible	Member pays 40% after deductible
Diagnostic X-Ray (office and/or outpatient facility)	Member pays 30% after deductible	Member pays 40% after deductible
Diagnostic Lab ▪ Office setting ▪ Facility setting	Member pays 30% after deductible Member pays 30% after deductible	Member pays 40% after deductible Member pays 40% after deductible

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Allergy Services ▪ Office visits ▪ Testing, treatment, injections and serum	 $35 copayment* Member pays 30% after deductible	 Member pays 40% after deductible Member pays 40% after deductible
Office Surgery (surgery and administration of general anesthesia)	Member pays 30% after deductible	Member pays 40% after deductible
Telemedicine Services	$35 copayment*	Member pays 40% after deductible
Telehealth Services – Online Physician Visit	$35 copayment*	Member pays 40% after deductible
Office Therapy Services ▪ Physical Therapy and Occupational Therapy: 20-visit benefit period maximum combined ▪ Speech Therapy: 20-visit benefit period maximum ▪ Chiropractic Care/Manipulation Therapy: 20-visit benefit period maximum	$35 copayment*	Member pays 40% after deductible
Other Therapy Services ▪ Chemotherapy, radiation therapy ▪ Cardiac Rehabilitation [There is no Cardiac Rehabilitation visit max on this plan; EHB benchmark plan indicates zero max; authorization required] and Respiratory/Pulmonary therapy	 Member pays 30% after deductible $35 copayment*	 Member pays 40% after deductible Member pays 40% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 30% after deductible	Member pays 40% after deductible
Urgent Care Center	Member pays 30% after deductible	Member pays 40% after deductible
Emergency Room Services ▪ Life-threatening illness or serious accidental injury only ▪ The ER copayment will be waived if admitted to the hospital	$250 copayment; then member pays 30%	$250 copayment; then member pays 30%
Outpatient Facility Services ▪ Surgery facility/hospital charges ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	 $250 copayment; then member pays 30% after deductible Member pays 30% after deductible Member pays 30% after deductible	 Member pays 40% after deductible Member pays 40% after deductible Member pays 40% after deductible
Inpatient Facility 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 ▪ Physician services (anesthesiologist, radiologist, pathologist)	 $500 copayment per admission; then member pays 30% after deductible Member pays 30% after deductible	 Member pays 40% after deductible Member pays 40% after deductible
Skilled Nursing Facility ▪ 30-day benefit period maximum	$500 copayment per admission; then member pays 30% after deductible	Member pays 40% after deductible
Mental Health/Substance Abuse Services ([2]services must be authorized by calling 1-800-292-2879) ▪ Inpatient mental health and substance abuse services[2] (facility fee) ▪ Inpatient mental health and substance abuse services[2] (physician fee) ▪ Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)[2] (facility and physician fee) ▪ Office mental health and substance abuse services (physician fee) ▪ Outpatient mental health and substance abuse services (physician fee)	 $500 copayment per admission; then member pays 30% after deductible Member pays 30% after deductible $250 copayment per admission; then member pays 30% after deductible $35 copayment* Member pays 30% after deductible	 Member pays 40% after deductible Member pays 40% after deductible Member pays 40% after deductible Member pays 40% after deductible Member pays 40% after deductible
Home Health Care Services ▪120-visit benefit period maximum	Member pays 30% after deductible	Member pays 40% after deductible

Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% after deductible	Member pays 30% after deductible
Durable Medical Equipment (DME)	Member pays 30% after deductible	Member pays 40% after deductible
Ambulance Services (covered when medically necessary)	Member pays 30% after deductible	Member pays 30% after deductible

Prescription Drugs Generic Premium

The Plan limits coverage of prescription drugs to only those listed on our generic premium formulary. Refer to last page for the generic premium formulary definition.

All member cost shares (copayments, coinsurance, and pharmacy deductible) for pharmacy benefits will apply to the plan Out-Of-Pocket Maximums.

Members must file a claim form for reimbursement when using an out-of-network pharmacy.

▪ Benefit Period Deductible (In-network and Out-of-network are combined)	$750 Individual / $1500 Family (does not apply to Tier 1 Retail or Tier 1 Home Delivery)
▪ Retail Drugs - Tier 1 (30 day supply)	$15 copayment
▪ Retail Drugs - Tier 2 (30 day supply)	$50 copayment after deductible
▪ Retail Drugs - Tier 3 (Specialty Drugs) (30 day supply)	Member pays 30% after deductible, up to a $500 maximum per prescription drug
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	$38 copayment
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	$125 copayment after deductible
▪ Home Delivery Maintenance Drugs - Tier 3 (Specialty Drugs) (30 day supply)	Member pays 30% after deductible, up to a $500 maximum per prescription drug
Out of Network (Deductible does not apply to Tier 1)	Member pays 30% after deductible

My Care Support

Tools and resources to help you stay healthy. Up to $600 in rewards and reimbursements. Eligible members include employees, spouses, and covered dependents age 18 and older.

▪ Tobacco-Free Reward	$50 gift card per member per benefit period
▪ Gym Reimbursement	Up to $400 per member per benefit period
▪ On-line Wellness Tools	Up to $150 in gift cards per member per benefit period

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

Generic Premium Formulary Definition

Your Plan limits coverage of Prescription Drugs to only those listed on our Generic Premium Formulary. We have developed this formulary as a lower cost program that contains a limited number of Prescription Drugs. Generally, the Generic Premium Formulary will include most Generic Drugs, and select Brand Name Drugs. Certain therapeutic classes may have no Brand Name Drugs on the formulary because of the number of Generic Drugs available in those therapeutic classes. We may add or delete Prescription Drugs from the Generic Premium Formulary from time to time. A description of the Prescription Drugs that are listed on the Generic Premium Formulary is available upon request and at www.bcbsga.com.

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:

- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Non-emergency use of the emergency room
- Removal/extraction of impacted teeth
- Private duty nursing
- 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 radiation for head and neck cancer
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational

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# POS-LG, 01012015* (the contract) for a complete explanation of covered services, limitations and exclusions.

The Power of Blue℠

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