



**This is only a summary for medical benefits.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsga.com](http://www.bcbsga.com) or by calling 1- 855-397-9267.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$500</b> Individual/ <b>\$1,500</b> Family for In Network providers. <b>\$1,000</b> Individual/ <b>\$3,000</b> Family for Out of Network providers.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Not for Medical. Dental plan has a \$50 deductible.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$1,000</b> Individual/ <b>\$3,000</b> Family for In Network providers. <b>\$4,000</b> Individual/ <b>\$12,000</b> Family for Out of Network providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Copayment amounts, Any member cost shares for pharmacy services, Premiums, Balance-billed Charges, and Healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

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**Blue Cross Blue Shield of Georgia**  
**Walton County BOC NS Blue Open Access POS**

Coverage Period: 07/01/2013 – 06/30/2014  
 Coverage for: Individual/Family | Plan Type: POS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.bcbsga.com">www.bcbsga.com</a> or call 1-855-397-8369 for a list of In Network providers	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
  - **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
  - The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
  - This plan may encourage you to use In Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 Copay/Visit	40% Coinsurance	—————none—————
	Specialist visit	\$35 Copay/Visit	40% Coinsurance	—————none—————
	Other practitioner office visit	\$15 Copay/Visit for Chiropractor	40% Coinsurance for Chiropractor	Coverage is limited to 20 visits per calendar year for Chiropractor. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	40% Coinsurance	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	—————none—————

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**Blue Cross Blue Shield of Georgia**  
**Walton County BOC NS Blue Open Access POS**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2013 – 06/30/2014

Coverage for: Individual/Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	—————none—————
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbsga.com">www.bcbsga.com</a> .	Tier 1 drugs	<b>\$10</b> Copay/Prescription for Retail Pharmacy and <b>\$20</b> Copay/Prescription for Home Delivery.	40% After Deductible.	30-day supply for Retail Pharmacy.  90-day supply for Home Delivery.
	Tier 2 drugs	<b>\$20</b> Copay/Prescription for Retail Pharmacy <b>\$40</b> Copay/Prescription for Home Delivery.	40% After Deductible.	30-day supply for Retail Pharmacy.  90-day supply for Home Delivery.
	Tier 3 drugs	<b>\$35</b> Copay/Prescription for Retail Pharmacy <b>\$70</b> Copay/Prescription for Home Delivery.	40% After Deductible.	30-day supply for Retail Pharmacy.  90-day supply for Home Delivery.
	Tier 4 (Specialty drugs)	<b>20%</b> , up to a <b>\$200</b> maximum per prescription drug for Retail Pharmacy and Home Delivery	<b>20%</b> , up to a <b>\$200</b> maximum per prescription drug for Retail Pharmacy and Home Delivery	30-day supply for Retail Pharmacy and Home Delivery.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	—————none—————
	Physician/surgeon fees	0% Coinsurance	40% Coinsurance	—————none—————

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2013 – 06/30/2014  
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Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
<b>If you need immediate medical attention</b>	Emergency room services	<b>\$100</b> Copay/Visit	<b>\$100</b> Copay/Visit	If admitted, the ER copay is waived.
	Emergency medical transportation	<b>0%</b> Coinsurance	<b>0%</b> Coinsurance	—————none—————
	Urgent care	<b>\$35</b> Copay/Visit	<b>\$35</b> Copay/Visit	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	<b>20%</b> Coinsurance	<b>40%</b> Coinsurance	—————none—————
	Physician/surgeon fee	<b>0%</b> Coinsurance	<b>40%</b> Coinsurance	—————none—————
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$25 Copay/ Visit	<b>40%</b> Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Mental/Behavioral health inpatient services	<b>20%</b> Coinsurance	<b>40%</b> Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Substance abuse disorder outpatient services	\$25 Copay/ Visit	<b>40%</b> Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Substance abuse disorder inpatient services	<b>20%</b> Coinsurance	<b>40%</b> Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
<b>If you are pregnant</b>	Prenatal and postnatal care	<b>0%</b> Coinsurance	<b>40%</b> Coinsurance	\$100 copay applies for initial prenatal visit.
	Delivery and all inpatient services	<b>20%</b> Coinsurance	<b>40%</b> Coinsurance	—————none—————

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2013 – 06/30/2014

Coverage for: Individual/Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	0% Coinsurance	40% Coinsurance	Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	\$35 Copay/Visit	40% Coinsurance	Coverage is limited to 20 visits per calendar year combined Physical and Occupational therapy. Coverage is limited to 20 visits per calendar year for Speech therapy. Coverage is limited to 36 visits per calendar year for Cardiac Rehabilitation.
	Habilitation services	\$35 Copay/Visit	40% Coinsurance	Coverage is limited to 20 visits per calendar year combined Physical and Occupational therapy. Coverage is limited to 20 visits per calendar year for Speech therapy. Coverage is limited to 36 visits per calendar year for Cardiac Rehabilitation.
	Skilled nursing care	0% Coinsurance	40% Coinsurance	Coverage is limited to 150 days per calendar year.
	Durable medical equipment	0% Coinsurance	40% Coinsurance	—————none—————
	Hospice service	No Charges	No Charges	—————none—————
	<b>If your child needs dental or eye care</b>	Eye exam	Not Covered Under Medical	Not Covered Under Medical
Glasses		Not Covered Under Medical	Not Covered Under Medical	See Vision Summary for Details
Dental check-up		Not Covered Under Medical	Not Covered Under Medical	See Dental Summary for Details

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### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) *See Dental Summary*
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult) *See Vision Summary*
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Most coverage provided outside the United States. See [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide)
- Non-emergency care when traveling outside the U.S.

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1- 855-397-9267. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

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## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Blue Cross Blue Shield of Georgia

PO box 9907

Columbus GA31908

## Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł íínizinigo t'áá diné k'éjúgo, t'áá shoodí ba na'ałníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalágú bich'í hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígí ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,440
- **Patient pays** \$1,100

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$500
Copays	\$100
Coinsurance	\$500
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,100</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,505
- **Patient pays** \$895

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$500
Copays	\$55
Coinsurance	\$340
Limits or exclusions	\$0
<b>Total</b>	<b>\$895</b>

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [800-638-4754].

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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