Your summary of benefits

BlueCross BlueShield Healthcare Plan of Georgia

Your Plan: BCBSHP Silver Blue Open Access POS 3500/0%/3500 w/HSA

1ZTT

Your Network: Blue Open Access POS

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal contract of coverage. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Overall Deductible *This is an embedded deductible plan. See notes section at the end of the document to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Retail Prescription Drug Coverage section.*	Member: $3,500 For Family: $7,000	Member: $7,000 For Family: $14,000
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section at the end of the document for additional information regarding your out of pocket maximum.* *For prescription drug, all cost shares count towards your plan's annual out-of-pocket limit.*	Member: $3,500 For Family: $7,000	Member: $8,750 For Family: $17,500
Doctor Home and Office Services		
Preventive care *In-network preventive care is not subject to deductible, if your plan has a deductible.*	Covered in full	30% coinsurance after deductible(deductible waived through age 5)
Primary care visit to treat an injury or illness	0% coinsurance after deductible	30% coinsurance after deductible
Specialist care visit	0% coinsurance after deductible	30% coinsurance after deductible
Prenatal and postpartum care	0% coinsurance after deductible	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Doctor Home and Office Services (*continued*)		
Other practitioner visits:		
Retail health clinic	0% coinsurance after deductible	30% coinsurance after deductible
On-line visit	0% coinsurance after deductible	30% coinsurance after deductible
Chiropractor services *Limited to 20 visits. Visit limit is combined both across outpatient and other professional visits, and in and out of network.*	0% coinsurance after deductible	30% coinsurance after deductible
Other services in an office:		
Allergy testing	0% coinsurance after deductible	30% coinsurance after deductible
Chemo/radiation therapy	0% coinsurance after deductible	30% coinsurance after deductible
Hemodialysis	0% coinsurance after deductible	30% coinsurance after deductible
Prescription drugs	0% coinsurance after deductible	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Diagnostic Services		
Lab:		
Freestanding/Reference Labs	0% coinsurance after deductible	30% coinsurance after deductible
Office *Office cost share applies only when Freestanding/Reference lab is not used.*	0% coinsurance after deductible	30% coinsurance after deductible
Outpatient hospital	0% coinsurance after deductible	30% coinsurance after deductible
X-ray:		
Office	0% coinsurance after deductible	30% coinsurance after deductible
Freestanding radiology center	0% coinsurance after deductible	30% coinsurance after deductible
Outpatient hospital	0% coinsurance after deductible	30% coinsurance after deductible
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible	30% coinsurance after deductible
Freestanding radiology center	0% coinsurance after deductible	30% coinsurance after deductible
Outpatient hospital	0% coinsurance after deductible	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Emergency and Urgent Care		
Urgent care (office setting)	0% coinsurance after deductible	30% coinsurance after deductible
Emergency room facility services	0% coinsurance after deductible	Same as In Network
Emergency room doctor and other services	0% coinsurance after deductible	Same as In Network
Ambulance (air and ground)	0% coinsurance after deductible	Same as In Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	0% coinsurance after deductible	30% coinsurance after deductible
Facility visit:		
Facility fees	0% coinsurance after deductible	30% coinsurance after deductible
Doctor services	0% coinsurance after deductible	30% coinsurance after deductible
Outpatient Surgery		
Facility fee:		
Freestanding surgical center	0% coinsurance after deductible	30% coinsurance after deductible
Hospital	0% coinsurance after deductible	30% coinsurance after deductible
Doctor services:		
Freestanding surgical center	0% coinsurance after deductible	30% coinsurance after deductible
Hospital	0% coinsurance after deductible	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) **Facility fee (for example, room & board)**	0% coinsurance after deductible	30% coinsurance after deductible
Doctor and other services	0% coinsurance after deductible	30% coinsurance after deductible
Recovery & Rehabilitation **Home health care** *Limited to 120 combined visits in and out of network. Visit limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.*	0% coinsurance after deductible	30% coinsurance after deductible
Rehabilitation services **(for example, physical/speech/occupational therapy):** Office Outpatient hospital *Limited to 20 combined visits for Physical and Occupational Therapy with an additional 20 separate visits for Speech Therapy services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	0% coinsurance after deductible 0% coinsurance after deductible	30% coinsurance after deductible 30% coinsurance after deductible
Cardiac rehabilitation Office Outpatient hospital	0% coinsurance after deductible 0% coinsurance after deductible	30% coinsurance after deductible 30% coinsurance after deductible
Skilled nursing care (in a facility) *Limited to 30 combined days per benefit period for Skilled Nursing Facility and Inpatient Rehabilitation services. Day limit is combined in and out of network.*	0% coinsurance after deductible	30% coinsurance after deductible
Durable medical equipment & prosthetics	0% coinsurance after deductible	30% coinsurance after deductible

Covered Prescription Drug Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Retail Prescription Drug Coverage ***This plan uses a Select Drug List. Drugs not on the list are not covered.***		
Deductible *Your plan deductible(s) apply to all pharmacy Tiers and both in-network and out-of-network services if your plan includes out-of-network coverage.*	Prescription Deductible (Member) : Combined with medical deductible Prescription Deductible (Family) : Combined with medical deductible	Prescription Deductible (Member) : Combined with medical deductible Prescription Deductible (Family) : Combined with medical deductible
Drug tier 1 - Typically Generic	0% coinsurance after deductible	30% coinsurance after deductible
Drug tier 2 - Typically Preferred / Formulary Brand	0% coinsurance after deductible	30% coinsurance after deductible
Drug tier 3 - Typically Non-preferred/Non-formulary and Specialty Drugs	0% coinsurance after deductible	30% coinsurance after deductible
Drug tier 4 - Typically Specialty Drugs	0% coinsurance after deductible	30% coinsurance after deductible

Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure Form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Children's and adult vision services count towards your out of pocket limit.*	*Eye exams are covered once per calendar year. For children through age 18, there is a selection of frames and contact lenses that are covered under this plan. Eyeglass lenses and Frames are covered once per calendar year. Contact Lens benefit available only if eyeglass lens benefit is not used. Review the formal contract of coverage or contact your vision provider for more information.*	*For covered services with a reimbursement amount, you will have no cost share up to that amount. All costs beyond the reimbursement amount are subject to balance billing.*
Children's Vision Essential Health Benefits		
Vision exam	$0 copay	$30 reimbursement
Frames	$0 copay	$45 reimbursement
Lenses		
Single	$0 copay	$25 reimbursement
Bifocal	$0 copay	$40 reimbursement
Trifocal	$0 copay	$55 reimbursement
Elective Contact Lenses	$0 copay	$60 reimbursement
Non-Elective Contact Lenses	$0 copay	$210 reimbursement

Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Adult Vision Benefits		
Vision exam	$20 copay	$30 reimbursement
Frames	Not covered	Not covered
Lenses		
Single	Not covered	Not covered
Bifocal	Not covered	Not covered
Trifocal	Not covered	Not covered
Elective Contact Lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Covered Dental Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure Form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive**	10% coinsurance	10% coinsurance
Basic services	40% coinsurance after deductible	40% coinsurance after deductible
Major services	40% coinsurance after deductible	40% coinsurance after deductible
Medically Necessary Orthodontia services ***(12 month waiting period)***	40% coinsurance after deductible	40% coinsurance after deductible
Cosmetic Orthodontia services	Not covered	Not covered
Deductible (Applies to all services except diagnostic & preventive)	Combined with Medical	Combined with Medical
Out-of-Pocket Limit	Combined with Medical	Combined with Medical
Adult Dental Benefits **Diagnostic and preventive**	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered

Out-of-Pocket Limit	Not covered	Not covered

Notes:

• The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

• Your copays, coinsurance and deductible count toward your out of pocket amount.

• If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.

• If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.

• When receiving care from providers out-of-network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out-of-network out-of-pocket limit.

• Human Organ and Tissues Transplants require precertification.

• 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.

• Physical Therapy: Athletic Trainers are covered by mandate for out-of-network only since athletic trainers are not contracted nor credentialed, therefore are not “in-network”.

• For additional information on this plan, please visit sbc.bcbsga.com to obtain a “Summary of Benefit Coverage”.