



BlueChoice Option (Open Access POS)
 Plan 260
 Georgia Bankers Association
 January 1, 2010

Deductibles, Maximums, etc.	In-Network Benefit Level	Out-of-Network Benefit Level
Deductible: one deductible for employee, one for spouse, one for all children combined		
– Individual	\$0	\$500
– Family	\$0	\$1,500
Coinsurance: the percentage of eligible charges for which you are responsible		
	Plan pays 90%	Plan pays 70%
Out-of-Pocket Calendar Year Maximum		
– Individual	\$500	\$1,500
– Family	\$1,500	\$4,500
Lifetime Maximum	Unlimited	\$2,000,000
Office Visits		
Preventive Health Care		
• Well-child care, immunizations	\$25 copayment	Plan pays 70%; annual deductible waived for well child care through age 5
• Periodic health examinations	\$25 copayment	Not covered
• Annual gynecology examination	\$35 copayment	Plan pays 70% after deductible for annual Pap and mammogram
• Prostate screening	\$25 copayment	Plan pays 70% after deductible for annual exam
Illness or Injury		
• Primary care physician (PCP) office visit (includes lab, radiology and office surgery)	\$25 copayment	Plan pays 70% after deductible
• Primary care physician after hours visit	\$30 copayment	Plan pays 70% after deductible
• Specialty care physician office visit	\$35 copayment	Plan pays 70% after deductible
• Second surgical	\$35 copayment	Plan pays 70% after deductible
• Allergy care (Primary care physician office visit, specialty care, allergy shots, serum and testing)	\$25 PCP copayment \$35 Specialist copayment	Plan pays 70% after deductible
• Maternity services (prenatal/delivery/ postpartum)	All physician charges related to prenatal, delivery and postpartum care are covered by \$35 copayment at first office visit	Plan pays 70% after deductible
• Vision care serviced provided by a network ophthalmologist or optometrist for treatment of acute conditions	\$35 copayment	Plan pays 70% after deductible
• Services provided by network dermatologists	\$35 copayment	Plan pays 70% after deductible

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Inpatient Services		
<ul style="list-style-type: none"> 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 Physician services (surgery, anesthesia, radiology, pathology, etc.) 	<p>Plan pays 90% after \$250 copayment per admission</p> <p>Plan pays 100%</p>	<p>Plan pays 70% after deductible and \$250 copayment per admission</p> <p>Plan pays 70% after deductible</p>
Outpatient Services		
<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Speech therapy Physical, occupational therapy Respiratory therapy Radiation therapy, chemotherapy 	<p>Plan pays 90%</p> <p>Plan pays 90%</p> <p>Plan pays 100%</p> <p>Plan pays 100%; 20-visit calendar year maximum</p> <p>Plan pays 100%; 20-visit calendar year maximum</p> <p>Plan pays 100%; 40-visit calendar year maximum</p> <p>Plan pays 100%</p>	<p>Plan pays 70% after deductible</p> <p>Plan pays 70% after deductible</p> <p>Plan pays 70% after deductible</p> <p>Plan pays 70% after deductible; 20-visit calendar year maximum</p> <p>Plan pays 70% after deductible; 20-visit calendar year maximum (includes Chiropractic care)</p> <p>Plan pays 70% after deductible; 40-visit calendar year maximum</p> <p>Plan pays 100%</p>
Annual visit limits are combined between in-network and out-of-network		
Emergency Room Services		
<ul style="list-style-type: none"> Life-threatening illness, serious accidental injury Non-emergency use of the emergency room Treatment of urgent illness or injury in network urgent care center 	<p>\$100 copayment, waived if admitted</p> <p>Not covered</p> <p>\$60 copayment</p>	<p>\$100 copayment, waived if admitted</p> <p>Not covered</p> <p>\$60 copayment; <i>then</i> Plan pays 70% after deductible</p>
Services must be authorized by Behavioral Health at 1-800-292-2879		
Behavioral Health/Substance Abuse Services		
<ul style="list-style-type: none"> Inpatient (facility and physician fee) Outpatient Inpatient alcohol or substance abuse detoxification 	<p>Plan pays 90% after \$250 copay per admission</p> <p>\$35 copayment</p> <p>Plan pays 90% after \$250 copay per admission</p>	<p>Plan pays 70% after deductible</p> <p>Plan pays 70% after deductible</p> <p>Plan pays 70% after deductible</p>
Other services		
<ul style="list-style-type: none"> Skilled nursing facility Home health care Hospice Care Ambulance 	<p>Plan pays 100%; 30-day calendar year maximum</p> <p>Plan pays 90%; 120-visit calendar year maximum</p> <p>Plan pays 100%; \$10,000 lifetime maximum</p> <p>Plan pays 100% when medically necessary</p>	<p>Plan pays 70% after deductible; 30-day calendar year maximum</p> <p>Plan pays 70% after deductible; 120-visit calendar year maximum</p> <p>Plan pays 100%; \$10,000 lifetime maximum</p> <p>Plan pays 100% when medically necessary</p>

Covered Services	In-Network Benefit Level	Out-of-Network Benefit
Prescription Drugs	In order to receive in-network benefit level, prescription must be written by either a network physician or ER physician	
<ul style="list-style-type: none"> Participating pharmacies include: Bi-Lo, CVS, Eckerd, Kmart, Kroger, Publix, Walgreens, WalMart, Winn-Dixie, and many independent pharmacies 	\$15 copayment for generic (up to 30-day supply); if generic alternative available to a brand name Rx, must choose generic; otherwise, \$60 copay will apply \$35 copayment for preferred name brands (up to 30-day supply) \$60 copayment for non-preferred brands (up to 30-day supply)	Plan pays 70% after deductible
Mail order prescriptions	\$30 copayment for preferred generics (up to 90-day supply) \$70 copayment for preferred name brands (up to 90-day supply)	Mail order prescriptions not available outside the network

Primary Care Physician

Under the Blue Open Access POS plan, you are not required to select a Primary Care Physician, or PCP, nor must a PCP coordinate your care with network specialist physicians.

For purposes of administering your benefits, a PCP is defined as a physician with a specialty of Internal Medicine, General Practice, Family Practice or Pediatrics.

In-Network versus Out-of-Network Services

As a BlueChoice Healthcare Plan member, covered services must be provided inside the BlueChoice Healthcare Plan network. Services provided outside the Blue Open Access POS network are not covered.

- In-Network Services** are those services provided by providers within the *Blue Open Access POS* network.
- Out-of-Network Services** are those services provided by a provider not participating in the *Blue Open Access POS* network. These services are not covered under Blue Open Access POS.

Pre-Existing Condition Limitation and Credit for Prior Coverage

Under Blue Open Access POS, there are no pre-existing condition limitations. All in-network, covered services are eligible for benefits from your first day of coverage.

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 or 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 dysfunction of any bodily organ.”

Prescription Drugs

BlueChoice Healthcare Plan 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. 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.



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