



Blue HSA and Gift Card Incentive Plan

Summary

The Blue® with HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you the benefits you would receive from a typical health plan, plus health care dollars to spend your way. And you can earn rewards for taking certain steps to improve your health.

Health Savings Account

With this plan you can **contribute pre-tax dollars to your HSA to pay for covered services**. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible. Unused dollars can be saved or invested and accumulate through retirement.

Contributions to Your HSA

For 2018, contributions can be made to your HSA up to the following:
 \$3,450 individual coverage
 \$6,900 family coverage

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* <ul style="list-style-type: none"> Individual Family 	\$2,700 \$5,400	\$8,100 \$16,200
Coinsurance	Member pays 20% Plan pays 80%	Member pays 50% Plan pays 50%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible) <ul style="list-style-type: none"> Individual Family 	\$6,350 \$12,700	\$15,000 \$30,000

*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 medical deductible and coinsurance on this plan will apply toward the out-of-pocket maximums. The following do not apply to out-of-pocket maximums: non-covered items, plan premiums, or any balance billing due to Out-of-Network services.

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) <ul style="list-style-type: none"> Well-child care, immunizations Periodic health examinations Annual gynecology examinations Prostate screenings 	Member pays 0% (not subject to deductible)	Member pays 50% after deductible (deductible waived through age 5)
Physician Office Visits for Illness and Injury <ul style="list-style-type: none"> Primary Care Physician (PCP) Specialist Physician 	Member pays 20% after deductible	Member pays 50% after deductible
Retail Health Clinic- (located in some pharmacies: search for in-network providers through Find a Doctor search tool on anthem.com) <ul style="list-style-type: none"> Immunizations Periodic health examinations 	Member pays 20% after deductible	Member pays 50% after deductible
Maternity Physician Services <ul style="list-style-type: none"> Global obstetrical care (prenatal, delivery and postpartum services) 	Member pays 20% after deductible	Member pays 50% after deductible
Diagnostic X-Ray (office and/or outpatient facility)	Member pays 20% after deductible	Member pays 50% after deductible
Diagnostic Lab <ul style="list-style-type: none"> Office setting Facility setting 	Member pays 20% after deductible Member pays 20% after deductible	Member pays 50% after deductible Member pays 50% after deductible
Allergy Services <ul style="list-style-type: none"> Office visits, testing and the administration of allergy injections Allergy injection serum 	Member pays 20% after deductible Member pays 20% after deductible	Member pays 50% after deductible Member pays 50% after deductible

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Office Surgery (surgery and administration of general anesthesia)	Member pays 20% after deductible	Member pays 50% after deductible
Online Medical Visit (https://livehealthonline.com)	Member pays 20% after deductible	Member pays 50% after deductible
Online Behavioral Health Visit (https://livehealthonline.com)	Member pays 20% after deductible	Member pays 50% after deductible
Office Therapy Services <ul style="list-style-type: none"> 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 	Member pays 20% after deductible	Member pays 50% after deductible
Other Therapy Services <ul style="list-style-type: none"> Chemotherapy, radiation therapy, cardiac rehabilitation (there is no Cardiac Rehabilitation visit max on this plan; authorization required) and respiratory/pulmonary therapy. 	Member pays 20% after deductible	Member pays 50% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 20% after deductible	Member pays 50% after deductible
Urgent Care Center	Member pays 20% after deductible	Member pays 50% after deductible
Emergency Room Services <ul style="list-style-type: none"> Life-threatening illness or serious accidental injury only 	Member pays 20% after deductible	Member pays 20% after deductible
Outpatient Facility Services <ul style="list-style-type: none"> Surgery facility/hospital charges Diagnostic x-ray and lab services Physician services (anesthesiologist, radiologist, pathologist) 	Member pays 20% after deductible Member pays 20% after deductible Member pays 20% after deductible	Member pays 50% after deductible Member pays 50% after deductible Member pays 50% after deductible
Inpatient Facility Services <ul style="list-style-type: none"> 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) 	Member pays 20% after deductible Member pays 20% after deductible	Member pays 50% after deductible Member pays 50% after deductible
Skilled Nursing Facility <ul style="list-style-type: none"> 60-day benefit period maximum 	Member pays 20% after deductible	Member pays 50% after deductible
Mental Health/Substance Abuse Services (services must be authorized by calling 1-800-292-2879) <ul style="list-style-type: none"> Inpatient mental health and substance abuse services (facility fee) Inpatient mental health and substance abuse services (physician fee) Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) (facility and physician fee) Office mental health and substance abuse services (physician fee) Outpatient mental health and substance abuse services (physician fee) 	Member pays 20% after deductible Member pays 20% after deductible Member pays 20% after deductible Member pays 20% after deductible Member pays 20% after deductible	Member pays 50% after deductible Member pays 50% after deductible Member pays 50% after deductible Member pays 50% after deductible Member pays 50% after deductible
Home Health Care Services <ul style="list-style-type: none"> 120-visit benefit period maximum 	Member pays 20% after deductible	Member pays 50% after deductible
Hospice Care Services <ul style="list-style-type: none"> Inpatient and outpatient services covered under the hospice treatment program 	Member pays 20% after deductible	Member pays 50% after deductible
Durable Medical Equipment (DME)	Member pays 20% after deductible	Member pays 50% after deductible
Ambulance Services (covered when medically necessary)	Member pays 20% after deductible	Member pays 20% after deductible

Prescription Drugs

Note:

- If a member receives a brand name drug that falls on Tier 2 or Tier 3 that has a generic equivalent available, the member pays the Tier 1 copay, plus the difference in cost between the brand drug and generic drug. This applies even when physician indicates DAW (dispense as written) or obtains an authorization.
- Current benefit period cost shares 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 applies prior to coinsurance

▪ Retail Drugs - Tier 1 (30 day supply)	20% coinsurance after deductible
▪ Retail Drugs - Tier 2 (30 day supply)	20% coinsurance after deductible
▪ Retail Drugs - Tier 3 (30 day supply)	20% coinsurance after deductible
▪ Retail Drugs - Tier 4 (Specialty Drugs) (30 day supply)	20% coinsurance after deductible
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	20% coinsurance after deductible
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	20% coinsurance after deductible
▪ Home Delivery Maintenance Drugs - Tier 3 (90 day supply)	20% coinsurance after deductible
▪ Home Delivery Maintenance Drugs - Tier 4 (Specialty Drugs) (30 day supply)	20% coinsurance after deductible

Plan Wellness Incentives

Tools and resources to help you and your family stay healthy. Incentives apply to eligible employees and spouses.

▪ Future Moms Program: 866-664-5404	Mothers-to-be can earn up to \$200 toward gift cards to national retailers for participating and get personalized support and guidance. You can call to speak to a nurse coach at 866-664-5404 for answers to your pregnancy questions — any time, any day
▪ Online Wellness Tool Kit To access the Online Wellness Tool Kit online, go to Anthem.com register or log in. Select the Health & Wellness tab then select the Wellness Tool Kit tab	Earn up to \$150 towards gift cards to national retailers when you participate in the Online Wellness Tool Kit. The Wellness Tool Kit is an online personalized well-being improvement program that focuses on physical, social and emotional behaviors that affect your total well-being. You start by completing a Health Assessment to help identify health goals and to develop a well-being plan. Your well-being plan uses the personal goals you set to keep you motivated, and it changes over time as you make progress toward them.
▪ Condition Care 800-638-4754	ConditionCare is a program that helps people with asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, coronary artery disease (CAD). When you join the program, we'll give you the tools and resources you need to take charge of your health. The BCBSGa care team may reach out to engage you or you can call us to sign up at no extra cost to you! Call today 800-638-4754 . You can earn \$100 for enrolling and upon graduation the reward is \$200. Rewards are given as Gift Cards.
▪ 24/7 NurseLine 888-724-2583	Access trained registered nurses any time of the day or night. Call 24/7 NurseLine at 888-724-2583 . Be sure to program this into your cell phone!

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

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, V6 01012018* (the contract) for a complete explanation of covered services, limitations and exclusions.



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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 333-5731.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

(Arabic) (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5731

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 333-5731

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。
。如需與譯員通話，請致電 (855) 333-5731

(Farsi) (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 333-5731 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5731.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5731.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5731

(Japanese) (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 333-5731 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5731 로 문의하십시오.

(Navajo) (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídlíkidgo ná bohónéedzǎ dóó bee ahóót'i' t'áa ni nizaad k'ehjí bee nił hodoonih t'áadoo bááłh ílinígóó. Ata' halne'ígíí łá' bich'í' hadeesdzih nínizingo koji' hodílnih (855) 333-5731.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 333-5731.

(Punjabi) (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇੱਕ ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 333-5731 ਤੇ ਕਾਲ ਕਰੋ।

(Russian) (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5731.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 333-5731.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 333-5731.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 333-5731.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.