Community Newspaper, Inc. - Blue Open Access POS
Large Group Benefit Summary

All benefits are subject to the calendar year deductible, except those with in-network copayments, unless otherwise noted.
All calendar year benefit visit 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	$5,000	$15,000
▪ Family	$10,000	$30,000
Coinsurance	Member pays 30% Plan pays 70%	Member pays 50% Plan pays 50%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible)		
▪ Individual	$7,000	$21,450
▪ Family	$14,000	$42,900
*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 applies to 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 and pharmacy copayments, deductible(s), 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, any balance billing due to Out-of-Network services, or any fourth quarter deductible amounts carried over from previous benefit period.		

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 50% after deductible (deductible waived through age 5)
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures)		
▪ Primary Care Physician (PCP)	Member pays 30% after deductible	Member pays 50% after deductible
▪ Specialist Physician	Member pays 30% 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 bcbsga.com) ▪ Immunizations ▪ Periodic health examinations	Member pays 30% after deductible	Member pays 50% after deductible
Maternity Physician Services ▪ Global obstetrical care (prenatal, delivery and postpartum services)	Member pays 30% after deductible	Member pays 50% after deductible
Online Medical Visit (https://livehealthonline.com)	Member pays 30% after deductible	Member pays 50% after deductible
Online Behavioral Health Visit (https://livehealthonline.com)	Member pays 30% after deductible	Member pays 50% after deductible
Allergy Services ▪ Office visits, testing and the administration of allergy injections	Member pays 30% after deductible	Member pays 50% after deductible
▪ Allergy injection serum	Member pays 30% 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 30% after deductible	Member pays 50% 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	Member pays 30% after deductible	Member pays 50% after deductible
Other Therapy Services ▪ Chemotherapy, radiation therapy, cardiac rehabilitation (there is no Cardiac Rehabilitation visit max on this plan; authorization required) and respiratory/pulmonary therapy	Member pays 30% after deductible	Member pays 50% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 30% after deductible	Member pays 50% after deductible
Urgent Care Services	Member pays 30% after deductible	Member pays 50% after deductible
Emergency Room Services ▪ Life-threatening illness or serious accidental injury only ▪ The ER copayment will be waived if admitted to the hospital	Member pays 30% after deductible	Member pays 30% after deductible
Outpatient Surgery at Free Standing Surgical Center ▪ Facility surgery charge ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 30% after deductible Member pays 30% after deductible Member pays 30% after deductible	Member pays 50% after deductible Member pays 50% after deductible Member pays 50% after deductible
Outpatient Surgery at Hospital ▪ Facility surgery charge ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist	Member pays 30% after deductible Member pays 30% after deductible Member pays 30% after deductible	Member pays 50% after deductible Member pays 50% after deductible Member pays 50% 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)	Member pays 30% after deductible	Member pays 50% after deductible
Skilled Nursing Facility ▪ 60-day benefit period maximum	Member pays 30% after deductible	Member pays 50% after deductible
Mental Health/Substance Abuse Services (*services must be authorized by calling 1-800-292-2879) ▪ Inpatient mental health and substance abuse services* (facility and 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 30% after deductible Member pays 30% after deductible Member pays 30% after deductible Member pays 30% 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 ▪ 120-visit benefit period maximum	Member pays 30% after deductible	Member pays 50% after deductible
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 30% after deductible	Member pays 50% after deductible
Durable Medical Equipment (DME)	Member pays 30% after deductible	Member pays 50% after deductible
Ambulance Services (covered when medically necessary)	Member pays 30% after deductible	Member pays 30% after deductible

Prescription Drugs (Option A) **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.	
Retail and Home Delivery maintenance drug coverage is provided at one of four tier levels in accordance with the Formulary Drug List. Members must file a claim form for reimbursement when using an out-of-network pharmacy. Specialty drugs can only be obtained from a Specialty Pharmacy.	
Benefit Period Deductible applies prior to coinsurance	
▪ Retail Drugs - Tier 1 (30 day supply)	30% coinsurance after deductible
▪ Retail Drugs - Tier 2 (30 day supply)	30% coinsurance after deductible
▪ Retail Drugs - Tier 3 (30 day supply)	30% coinsurance after deductible
▪ Retail Drugs - Tier 4 (Specialty Drugs) (30 day supply)	30% coinsurance after deductible
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	30% coinsurance after deductible
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	30% coinsurance after deductible
▪ Home Delivery Maintenance Drugs - Tier 3 (90 day supply)	30% coinsurance after deductible
▪ Home Delivery Maintenance Drugs - Tier 4 (Specialty Drugs) (30 day supply)	30% coinsurance after deductible

Prescription Drug Tier Definitions

Tier 1 **–** These drugs have the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.

Tier 2 **–** These drugs will have a higher copayment than tier 1 drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

Tier 3 **–** These drugs will have a higher copayment than tier 2 drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single source brand drugs, or multi-source brands drugs.

Tier 4 – Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier will contain Specialty Drugs.

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 **bcbsga.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 Took 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.
▪ 24/7 NurseLine **888-724-2583**	Access to Registered nurses any time of the day or night. Call 24/7 NurseLine at **888-724-2583**.

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.

BlueCross BlueShield Healthcare Plan of Georgia

The Power of Blue℠

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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)

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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

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