Berry College

POS
Summary
of Benefits

BlueChoice Option (POS) Benefit Summary

	In-Network Benefit Level	Out-of-Network Benefit Level
Deductibles, Maximums, Etc.		
• Deductible: one deductible for employee, one for spouse, one for all children combined		
- Individual	• $0	• $300
- Family	• $0	• $900
• Coinsurance: the percentage of eligible charges for which you are responsible	• Plan pays 80%	• Plan pays 60%
• Out-of-Pocket Calendar Year Maximum		
- Individual (excludes deductible)	• $1,000	• $2,000
- Family (excludes deductible)	• $3,000	• $6,000
• Lifetime Maximum	• Unlimited	• $5,000,000
Office Visits		
Preventive Health Care		
• Well-child care, immunizations	• $25 copayment	• Plan pays 60%; annual deductible waived for well child care through age 5
• Periodic health examinations	• $25 copayment	• Not covered
• Annual gynecology examination (No PCP referral required - Must use network provider for in-network benefits)	• $30 copayment	• Plan pays 60% after deductible for annual Pap and mammogram
• Prostate screening	• $25 copayment	• Plan pays 60% after deductible for annual exam
Illness or Injury		
• Primary care physician (PCP) office visit (includes lab, radiology and office surgery)	• $25 copayment	• Plan pays 60% after deductible
• Primary care physician after hours office visit	• $30 copayment	• Plan pays 60% after deductible
• Specialty care physician office visit (PCP referral required)	• $30 copayment	• Plan pays 60% after deductible
• Second surgical opinion (PCP referral required)	• $30 copayment	• Plan pays 60% after deductible
• Allergy care (Primary care physician office visit, specialty care, allergy shots, serum and testing)	• $25 PCP copayment • $30 specialist copayment	• Plan pays 60% after deductible
• Maternity services (prenatal/delivery/postpartum)	• All physician charges related to prenatal, delivery and post-partum care are covered by $30 copayment at first office visit	• Plan pays 60% after deductible
• Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions (No PCP referral required)	• $30 copayment	• Plan pays 60% after deductible
• Services provided by network dermatologists (No PCP referral required)	• $30 copayment	• Plan pays 60% after deductible
Inpatient 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	• Plan pays 80%	• Plan pays 60% after deductible
• Physician services (surgery, anesthesia, radiology, pathology, etc.)	• Plan pays 100%	• Plan pays 60% after deductible

	In-Network Benefit Level	Out-of-Network Benefit Level
Outpatient Services		
• Facility/hospital charges (including diagnostic x-ray	• Plan pays 80%	• Plan pays 60% after deductible

and lab services)		
• Outpatient surgery outside physician's office (facility component only)	• Plan pays 80%	• Plan pays 60% after deductible
• Physician services (surgery, anesthesia, radiology, pathology, etc.)	• Plan pays 100%	• Plan pays 60% after deductible
• Chiropractic Care	• $15 copayment; 20-visit calendar year maximum	• Not covered
• Therapy services:	**Annual visit limits are combined between in-network and out-of-network**	
- Speech therapy	• $30 copayment; 20-visit calendar year maximum	• Plan pays 60% after deductible; 20-visit calendar year maximum
- Physical, occupational therapy	• $30 copayment; 20-visit calendar year maximum	• Plan pays 60% after deductible; 20-visit calendar year maximum (includes Chiropractic care)
- Respiratory therapy	• Plan pays 100%; 40-visit calendar year maximum	• Plan pays 60% after deductible; 40-visit calendar year maximum
- Radiation therapy, chemotherapy	• Plan pays 100%	• Plan pays 60% after deductible
Emergency Room Services		
• Life-threatening illness, serious accidental injury or with a PCP referral	• $75 copayment, waived if admitted	• $75 copayment, waived if admitted
• Non-emergency use of the emergency room	• Not covered	• Not covered
Mental Health/Substance Abuse Services (Provided through Blue Cross Blue Shield Of Georgia)	**No Primary Care Physician referral required. Services must be authorized by Blue Cross Blue Shield of Georgia at 1-800-292-2879.**	
• Inpatient (facility and physician fee)	• Plan pays 80%; 30-day calendar year maximum	• Not covered
• Outpatient	• $30 copayment; 20-visit calendar year maximum	• Not covered
• Inpatient alcohol or substance abuse detoxification	• Plan pays 80%; 6-day calendar year maximum (combined with other inpatient mental health and substance abuse benefits)	• Not covered
Other Services	**Annual maximum is combined between in-network and out-of-network**	
• Skilled nursing facility	• Plan pays 100%; 30-day calendar year maximum	• Plan pays 60% after deductible; 30-day calendar year maximum
• Home health care	• Plan pays 100%; 120-visit annual maximum	• Plan pays 60% after deductible; 120-visit calendar year maximum
• Hospice care	• Plan pays 100%; $10,000 lifetime maximum	• Plan pays 100%; $10,000 lifetime maximum
• Ambulance	• Plan pays 100% when medically necessary	• Plan pays 100% when medically necessary

Prescription Drugs

- **BENEFITS FOR PRESCRIPTION DRUGS WILL NOT BE COVERED UNDER THIS PLAN.**
- **PLEASE CONTACT Wellnet Healthcare AT 1-800-727-1733-EFFECTIVE 5-1-2005.**

Primary Care Physician

A primary care physician, or PCP, is a doctor who specializes in family or general practice, internal medicine or pediatrics and participates in the BlueChoice Option network. Each BlueChoice Option member must select a PCP. Your PCP is responsible for providing or coordinating necessary care for you 24 hours per day, 7 days a week. For additional medical information call BlueChoice On-Call, available 24 hours per day, 7 days a week.

In-Network versus Out-of-Network Services

As a BlueChoice Option member, you have the ability to receive services either from providers in the BlueChoice Option network or outside this network. Generally, you will pay less out of your own pocket if you elect in-network services.

- **In-Network Services** are those services that are either provided or coordinated by your PCP. Some services do not require PCP coordination. Please keep in mind that even though a referral is not required for certain services, you must select a provider from the network directory to receive in-network benefits. Services that do not require a PCP referral include:
  - ***OB/GYN*** services for the treatment of an obstetrical or gynecological-related condition
  - ***Covered Vision Care Services -*** from a networkophthalmologist or optometrist (Routine vision services may not be covered under your policy - if you do not know if you have routine vision coverage, please call customer service at 1-800-441-2273).
  - ***Dermatological care***for skin-related conditions
  - ***Mental Health or Substance Abuse benefits***- You may contact Blue Cross Blue Shield of Georgia directly at 1-800-292-2879 without contacting your PCP.
- **Out-of-Network Services** are those services that your PCP did not coordinate. For services outside the network, you will be responsible for satisfying an annual deductible, after which you will pay a percentage of the total charge called coinsurance.

Pre-Existing Condition Limitation and Credit for Prior Coverage

For in-network services, there is no pre-existing condition limitation. For out-of-network services, benefits are not available during a pre-existing limitation period for services for any illness, injury or condition for which medical advice or treatment was recommended by, or received from, a health care provider within six months preceding the effective date of coverage. *The pre-existing limitation period may be reduced or eliminated by the submission of a certificate of prior creditable coverage.* The pre-existing limitation period does not apply to maternity services.

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 of 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 dysfunctions of any bodily organ."

Prescription Drugs

- This plan does not include Prescription Drug Coverage.

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:

- 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 extraction of impacted teeth
- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Surgical or medical care for: artificial insemination, in-vitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood
- Smoking cessation products

Prior Authorization

Your PCP must coordinate most in-network services. For in-network services, your PCP (or the specialist to whom you were referred by your PCP) will be responsible for ensuring that any surgical procedures or inpatient admissions obtain the necessary prior authorization. For out-of-network services, you should be sure that Blue Cross Blue Shield Healthcare Plan of Georgia has authorized the following procedures prior to these services being rendered:

- Home health care services
- All outpatient surgery, including laproscopic and arthroscopic procedures
- Durable Medical Equipment over $250
- MRIs
- EMGs
- All scopes, including endoscopy and colonoscopy
- Myelography
- Cardiac catheterization

NOTE: This list is subject to change.

If you receive out-of-network treatment and prior authorization was not obtained, all charges will be denied. You, the member, will be responsible for all charges.

Additional Information

Should you need additional information, the best sources are your *Provider Directory/Member Guide* and your *Certificate Booklet*. You may also visit our web site at www.bcbsga.com for more information. If you have specific questions that require an answer from our representatives, please call one of the following numbers:

- Customer Service **1-800-441-2273**
- Mental Health/Substance Abuse Services) **1-800-292-2879**
- BlueChoice On-Call **1-888-724-2583**

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 # F-1681.772* (the contract) for a complete explanation of covered services, limitations and exclusions.

Blue Cross Blue Shield Healthcare Plan of Georgia • 3350 Peachtree Road, NE • Atlanta, Georgia 30326 • 1-800-441-2273

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