Berry College
BlueChoice Gate Keeper HMO Benefit Summary

All benefits are subject to the calendar year deductible, except those with in-network copayments, unless otherwise noted.
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.

Deductibles, Coinsurance and Maximums	In-Network Benefit Level
Calendar Year Deductible*	
▪ Individual	$0
▪ Family	$0
Coinsurance	Member pays 0% Plan pays 100%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible)	
▪ Individual	$1,000
▪ Family	$3,000
Lifetime Maximum	Unlimited

*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 following do not apply to out-of-pocket maximums: non-covered items and any member cost shares for pharmacy services. The medical copayments on this plan will apply toward the out-of-pocket maximums.

Covered Services	In-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 (no PCP referral required) ▪ Prostate screenings	Member pays 0%
Physician Office Visits for Illness and Injury (including labs, x-rays and diagnostic procedures)	
▪ Primary Care Physician (PCP)*	$25 copayment
▪ OB/GYN (no referral)	$25 copayment
▪ Specialist Physician (PCP referral required except dermatologists, ophthalmologists and optometrists for treatment of acute eye conditions)	$30 copayment
*Also applies to services rendered at Retail Health Clinics	
Maternity Physician Services ▪ 1st Prenatal visit (including global obstetrical care **[**prenatal, delivery and postpartum services])	$25 copayment
Telemedicine Services	$25 PCP copayment or $30 Specialist copayment
Allergy Services (office visits, testing , serum, and administration of allergy injections)	$25 PCP copayment or $30 Specialist copayment
Office Surgery (surgery and administration of general anesthesia)	$25 PCP copayment or $30 Specialist copayment

Covered Services	In-Network Benefit Level
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	 $25 PCP copayment or $30 Specialist copayment
Other Therapy Services (chemotherapy, cardiac rehabilitation [There is no Cardiac Rehabilitation visit max on this plan; EHB benchmark plan indicates zero max; authorization required] and respiratory/pulmonary therapy ▪ Office setting ▪ Facility setting	 $25 PCP copayment or Member pays 0%
Other Therapy Services (radiation therapy) ▪ Office setting ▪ Facility setting	 Member pays0% Member pays 0%
Advanced Diagnostic Imaging (MRI, MRA, CT Scan and PET Scan) ▪ Office setting ▪ Facility setting	 $25 PCP copayment or $30 Specialist copayment Member pays 0%
Urgent Care Center	$60 copayment
Emergency Room Services ▪ Life-threatening illness or serious accidental injury only ▪ The ER copayment will be waived if admitted to the hospital	$75 copayment; then member pays 0%
Outpatient Facility Services ▪ Surgery facility/hospital charges ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	 $100 copayment Member pays 0% Member pays 0%
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 0%
Skilled Nursing Facility ▪ 30-day benefit period maximum	Member pays 0%
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/Outpatient mental health and substance abuse services (physician fee)	 Member pays 0% Member pays 0% $25 copayment
Home Health Care Services ▪ 120-visit benefit period maximum	$25 copayment
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0%
Durable Medical Equipment (DME)	Member pays 0%
Ambulance Services ▪ Covered when medically necessary	Member pays 0%

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# HMO-LG, 01012014* (the contract) for a complete explanation of covered services, limitations and exclusions.

Gatekeeper HMO Plan Design Number Legend
GKH = gatekeeper HMO
5 = copay and deductible/coinsurance benefit plans
A = Rx option A

BlueCross BlueShield Healthcare Plan of Georgia

The Power of Blue℠

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