

Berry College

Blue Open Access POS Benefit Summary



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

All calendar year 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 * <ul style="list-style-type: none"> ▪ Individual ▪ Family 	\$0 \$0	\$300 \$900
Coinsurance	Member pays 20% Plan pays 80%	Member pays 40% Plan pays 60%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible) <ul style="list-style-type: none"> ▪ Individual ▪ Family 	\$1,000 \$3,000	\$2,000 \$6,000
Lifetime Maximum	Unlimited	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	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%	Member pays 30% after deductible (deductible waived through age 5)
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures) <ul style="list-style-type: none"> ▪ Primary Care Physician (PCP)* ▪ OB/GYN ▪ Specialist Physician 	\$25 copayment \$25 copayment \$30 copayment	Member pays 40% after deductible
*Also applies to services rendered at Retail Health Clinics		
Maternity Physician Services <ul style="list-style-type: none"> ▪ 1st Prenatal visit ▪ Global obstetrical care (prenatal, delivery and postpartum services) 	\$25 copayment at initial visit Member pays 0%	Member pays 40% after deductible
Telemedicine Services	\$25 PCP copayment or \$30 Specialist copayment	Member pays 40% after deductible
Allergy Services <ul style="list-style-type: none"> ▪ Office visits, testing and the administration of allergy injections ▪ Allergy injection serum 	\$25 PCP copayment or \$30 Specialist copayment Member pays 20%	Member pays 40% after deductible Member pays 40% after deductible

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Office Surgery (surgery and administration of general anesthesia)	\$25 PCP copayment or \$30 Specialist copayment	Member pays 40% 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 	\$25 copayment	Member pays 40% after deductible
Other Therapy Services (cardiac rehabilitation [There is no Cardiac Rehabilitation visit max on this plan; EHB benchmark plan indicates zero max; authorization required] and respiratory/pulmonary therapy)	Member pays 20%	Member pays 40% after deductible
Other Therapy Services (chemotherapy, radiation therapy)	Member pays 0%	Member pays 40% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 20%	Member pays 40% after deductible
Urgent Care Services	\$60 copayment	Member pays 40% after deductible
Emergency Room Services <ul style="list-style-type: none"> Life-threatening illness or serious accidental injury only The ER copayment will be waived if admitted to the hospital 	\$75 copayment	\$75 copayment
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% Member pays 20%	Member pays 40% 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%	Member pays 40% after deductible
Skilled Nursing Facility <ul style="list-style-type: none"> 30-day benefit period maximum 	Member pays 20%	Member pays 40% 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 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 20% Member pays 20% \$25 copayment	Member pays 40% after deductible Member pays 40% after deductible Member pays 40% after deductible
Home Health Care Services <ul style="list-style-type: none"> 120-visit benefit period maximum 	\$25 copayment	Member pays 40% after deductible
Hospice Care Services <ul style="list-style-type: none"> Inpatient and outpatient services covered under the hospice treatment program 	Member pays 0%	Member pays 30% after deductible
Durable Medical Equipment (DME)	Member pays 20%	Member pays 40% after deductible
Ambulance Services (covered when medically necessary)	Member pays 20%	Member pays 20% after deductible

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

Open Access POS Plan Design Number Legend
OAP = Open Access POS
5 = copay and deductible/coinsurance benefit plans
A = Rx option A



The Power of BlueSM

3350 Peachtree Road, NE • Atlanta, Georgia 30326 • 1-855-397-9267
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., is an independent licensee of the Blue Cross and Blue Shield Association.
The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
02599GAMENBGA- eff 1/1/14
Custom Summary (Original Plan OAP5 500/80A)-revised 03/19/2014
Effective 05/2014