



2011 Benefits Package

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BlueChoice PPO – Lee County BOC 2011 Plan G4503SX NS 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.

When using out-of-network providers, members are responsible for any difference between the allowed amount & actual 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 (combined for in- and out-of-network): <i>one deductible for employee, one for spouse, one for all eligible children combined</i> <ul style="list-style-type: none"> - Individual - Family 	\$500 \$1,500	\$1,000 \$3,000
Coinsurance	Plan pays 80% after deductible Member pays 20% after deductible	Plan pays 60% after deductible Member pays 40% after deductible
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Calendar Year Maximum* <ul style="list-style-type: none"> - Individual - Family 	\$2,000 \$6,000	\$4,000 \$12,000
*Maximum of three (3) per family (one for employee, one for spouse and one for all eligible children combined). The following do not apply to out-of-pocket maximums: deductibles, copayment amounts, non-emergency room copayments and non-covered items. Amounts satisfied toward the out-of-network, out-of-pocket limit will also be applied toward the in-network, out-of-pocket limit. Amounts satisfied toward the in-network, out-of-pocket will not be applied toward the out-of-network, out-of-pocket limit.		
Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Office Visits: Preventive Care		
Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.		
• Well-child care, immunizations	\$25 copayment	Plan pays 60% after deductible <i>(deductible waived through age 5)</i>
• Periodic health examinations	\$25 copayment	Plan pays 60% after deductible
• Annual gynecology examination	\$25 copayment	Plan pays 60% after deductible
• Prostate screening	\$25 copayment	Plan pays 60% after deductible
Illness or Injury		
• Preferred Physician office visit (including diagnostic x-rays and laboratory performed in physician's office)	\$25 copayment	Plan pays 60% after deductible
• Specialist Physician office visit (including diagnostic x-rays and laboratory performed in physician's office)	\$25 copayment	Plan pays 60% after deductible
• Surgery in physician's office	Plan pays 80% after deductible	Plan pays 60% after deductible
• Allergy care (testing, serum, and allergy shots)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Maternity physician services (prenatal, delivery, postpartum)	\$100 copayment <i>(first office visit only)</i>	Plan pays 60% after deductible
Emergency Room Services		
• Life-threatening illness or serious accidental injury	\$100 copayment <i>(waived if admitted)</i>	\$100 copayment <i>(waived if admitted)</i>
• Non-emergency use of the emergency room	\$100 copayment; plan pays 80% after copayment and deductible	\$100 copayment; plan pays 60% after copayment and deductible
Inpatient Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Plan pays 80% after deductible	Plan pays 60% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible	Plan pays 60% after deductible

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Outpatient Services		
• Surgery facility/hospital charges	Plan pays 80% after deductible	Plan pays 60% after deductible
• Diagnostic X-ray and lab services	Plan pays 80% after deductible	Plan pays 60% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible	Plan pays 60% after deductible
Therapy Services Calendar year maximums are combined between in-network and out-of-network.		
• Speech therapy	Plan pays 80% after deductible; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
• Physical, occupational therapy, chiropractic care and services of athletic trainers	Plan pays 80% after deductible; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
• Respiratory therapy	Plan pays 80% after deductible; 30-visit calendar year maximum	Plan pays 60% after deductible; 30-visit calendar year maximum
• Radiation therapy and chemotherapy	Plan pays 80% after deductible	Plan pays 60% after deductible
Mental Health/Substance Abuse Services must be authorized by calling 1-800-292-2879.		
• Inpatient (facility and physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Inpatient Substance Abuse Detoxification (facility and physician fee)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Partial Hospitalization Program (facility and physician fee)	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 70% after deductible
• Intensive Outpatient Program (facility and physician fee)	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 70% after deductible
• Professional Outpatient Services	\$25 copayment	Plan pays 60% after deductible
Other Services Calendar year maximums are combined between in-network and out-of-network.		
• Urgent Care Center	\$60 copayment	\$60 copayment; plan pays 70% after copayment and deductible
• Skilled Nursing Facility	Plan pays 80% after deductible; 30-day calendar year maximum	Plan pays 60% after deductible; 30-day calendar year maximum
• Temporomandibular Joint Dysfunction (TMJ)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Home Health Care	\$25 copayment per visit; 120-visit calendar year maximum	Plan pays 60% after deductible; 120-visit calendar year maximum
• Hospice Care	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 100% (<i>not subject to deductible</i>)
• Ambulance (when medically necessary)	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 100% (<i>not subject to deductible</i>)
Prescription Drugs		
Retail and mail order maintenance drug coverage is provided at one of three tier levels in accordance with the Formulary Drug List when drugs are purchased at an in-network or out-of-network pharmacy. 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. Refer to last page for Tier definitions.	Unless otherwise indicated in the Certificate Booklet, each retail prescription has a 30-day supply limit and each mail order maintenance prescription has a 90-day supply limit.	
• Retail Drug - Generic	\$15 copayment per prescription	
• Retail Drug - Brand	\$30 copayment per prescription	

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

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Pre-Existing Condition Limitation and Credit for Prior Coverage

Until a member has had creditable coverage for 12 consecutive months, benefits for services shall not be available 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 (excluding newborns, members under age 19, adoptions, placements for adoption and pregnancies for which the pre-existing condition limitation is not applicable).

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
- Smoking cessation products

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-1681.792* (the contract) for a complete explanation of covered services, limitations and exclusions.

Blue Cross and Blue Shield of Georgia believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Blue Cross and Blue Shield of Georgia at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.



The Power of BlueSM

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WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!



Blue View VisionSM



Your Blue View Vision network

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Target® Optical, JCPenney Optical, Sears Optical and Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at (866) 723-0515 with questions about vision benefits or provider locations.

Out-of-network services

Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward services and you pay the rest. (In-network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES

Routine eye exam Each calendar year

Eyeglass frames

Every two years you may select any eyeglass frame and receive the following allowance toward the purchase price:

Eyeglass lenses (Standard)

Factory scratch coating included

Polycarbonate lenses included for children under 19 years old.

Transitions lenses included for children under 19 years old.

Each calendar year you may receive any one of the following lens options:

- Standard plastic single vision lenses (1 pair)
- Standard plastic bifocal lenses (1 pair)
- Standard plastic trifocal lenses (1 pair)

Eyeglass lens upgrades

When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass copayment applies.

Lens Options

- UV Coating
- Tint (Solid and Gradient)
- Standard Polycarbonate
- **Transitions** lenses
- Other Photochromics
- Progressive Lenses¹
 - Standard
 - Premium Tier 1
 - Premium Tier 2
 - Premium Tier 3
- Standard Anti-Reflective Coating²
- Premium Tier 1 Anti-Reflective Coating²
- Premium Tier 2 Anti-Reflective Coating²
- Other Add-ons and Services

Contact lenses

Every two years

Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses and receive an allowance toward the cost of a supply of contact lenses. *Your contact lens allowance must be used at the time of initial service.*

- Elective Conventional Lenses
- Elective Disposable Lenses
- Non-Elective Contact Lenses

No amount over the allowance may be carried forward to subsequent materials in the same or the following calendar year.

IN-NETWORK

OUT-OF-NETWORK

\$10 copay; then covered in full

\$30 allowance

\$130 allowance then 20% off remaining balance

\$45 allowance

\$20 copay; covered in full
\$20 copay; covered in full
\$20 copay; covered in full

\$25 allowance
\$40 allowance
\$55 allowance

Member cost for upgrades

\$15
\$15
\$40
\$75
\$75

\$65
\$91
\$97
\$103
\$45
\$57
\$68

20% off retail price

\$130 allowance then 15% off the remaining balance

Discounts on lens upgrades are not available out-of-network

\$105 allowance

\$130 allowance (no additional discount)

\$105 allowance

Covered in full

\$210 allowance

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!



VISION CARE SERVICES

Contact lens fitting and follow-up

A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.

- Standard contact fitting*
- Premium contact lens fitting**

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specially fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

IN-NETWORK Member Cost
 Fitting and follow up visits up to \$55
 10% off retail price

OUT-OF NETWORK
 Discounts not available out-of-network

Discounts – Savings on additional eyewear and accessories – After you use your initial frame or contact lens allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

<p>BLUE VIEW VISION ADDITIONAL SAVINGS</p> <p>Additional Pair of Complete Eyeglasses</p> <p>Contact Lenses - Conventional <i>(Discount applied to materials only)</i></p> <p>Eyewear Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.</p> <p><small>*Items purchased separately are discounted 20% off the retail price. Blue View Vision's Additional Savings Program is subject to change without notice.</small></p>	<p>MEMBER SAVINGS</p> <p>40% discount off retail*</p> <p>15% off retail price</p> <p>20% off retail price</p>	<p>LASER VISION CORRECTION SURGERY Glasses or contacts may not be the answer for everyone. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to SpecialOffers at bcbsga.com and select vision care.</p> <p>USING YOUR BLUE VIEW VISION PLAN The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.</p> <p>OUT-OF-NETWORK If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt to the below fax number, email address, or mailing address. When visiting an out-of-network provider, you are responsible for payment of services and/or eyewear materials at the time of service.</p> <p>To Fax: 866-293-7373 To Email: oonclaims@eyewearspecialoffers.com To Mail: Blue View Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111</p>
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EXCLUSIONS & LIMITATIONS

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design; however, these materials and any items not covered below may be purchased at preferred pricing from Blue View Vision provider. In addition, benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

- Combined Offers.** Not combined with any offer, coupon, or in-store advertisement.
- Experimental or Investigative.** Any experimental or investigative services or materials.
- Crime or Nuclear Energy.** Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available
- Uninsured.** Services received before insured person's effective date or after coverage ends.
- Excess Amounts.** Any amounts in excess of covered vision expense.
- Routine Exams or Tests.** Routine examinations required by an employer in connection with insured person's employment.
- Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits.
- Government Treatment.** Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free.
- Services of Relatives.** Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage.
- Voluntary Payment.** Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage.
- Not Specifically Listed.** Services not specifically listed in this plan as covered services.

- Private Contracts.** Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
- Eye Surgery.** Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.
- Sunglasses.** Sunglasses and accompanying frames.
- Safety Glasses.** Safety glasses and accompanying frames.
- Hospital Care.** Inpatient or outpatient hospital vision care.
- Orthoptics.** Orthoptics or vision training and any associated supplemental testing.
- Non-Prescription Lenses.** Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
- Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames, unless insured person has reached a new benefit period.
- Frames:** Discount is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Disclaimer**
This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's Policy, which shall control in the event of a conflict with this overview.

The in-network vision providers referred to in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Blue Cross Blue Shield of Georgia.

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 Blue View Vision GA Group Full Service (9/08)

**Lee County BOC
Benefit Summary Plan NS135 w/Ortho**

Dental



		In-Network Dentist	Out-of-Network Dentist
Calendar Year Deductible		\$50/member; maximum of \$150 family	
		<ul style="list-style-type: none"> • Applies to Basic and Major Services • Maximum of three deductibles per family • No Deductible on Preventive Services 	
Annual Maximum		\$1,500\ \$1,000 Lifetime Orthodontics	
Coinsurance Amounts		100% Preventive Services 85% Basic Services 50% Major Services 50% Orthodontic Services	100% Preventive Services 85% Basic Services 50% Major Services 50% Orthodontic Services
Predetermination of Benefits		Recommended for charges in excess of \$350	
See Certificate Booklet for Complete Details:		It is important to keep in mind that this material is a brief outline of benefits and covered service and is not a contract. Please refer to your Certificate Booklet (the Contract) for a complete explanation of covered services, limitations and exclusions.	

In & Out of Network Dental Coinsurance Covered Procedures

100% Preventive Services

- Routine oral examinations
- Prophylaxis (two per year)
- Topical applications of fluoride
- Space maintainers
- Diagnostic casts
- Pulp vitality testing (one per year)
- Dental X-rays
- Sealants

85% Basic Services

- Fillings
- Oral surgery
- Endodontics
- Simple extractions
- Periodontic services
- Other visits and exams
- Palliative emergency treatment
- Occlusal guards (one per year)

50% Major Services

- Inlays
- Crowns
- Bridges
- Dentures
- Denture rebase or reline
- Repair of fixed bridge
- Repair of removable dentures
- Re-cement crowns and bridges

50% Orthodontic Services

Lifetime Maximum \$1000 for dependents up to age 19

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