Summary of Benefits	In-Network	Out-of-Network
This **Summary of Benefits** explains the extent to which Covered Services are available to covered persons on this Contract. Your Copayment, Coinsurance, maximums and limits for Covered Services are shown below and are per covered person. This Summary is not a complete explanation of these benefits. To understand them, you must read this **Summary of Benefits** and your Contract. All Covered Services shall be provided subject to all terms and conditions stated in the Contract.		
Lifetime Maximums		
Lifetime Maximum Benefits **All benefits combined:** In-Network and Out-of-Network	$5,000,000	
Lifetime Maximum Benefits for TMJ (included in total maximum) In-Network and Out-of-Network combined	$5,000	
Lifetime Maximum Benefits for Hospice Care (included in total maximum) In-Network and Out-of-Network combined	$10,000	
Calendar Year Deductible **All services are subject to a Deductible per Benefit Period unless otherwise stated. No benefits are payable until the Calendar Year Deductible is satisfied.**		
Deductible **Aggregate Deductible**	$3,500 $7,000	$3,500 $7,000
All services and all calendar year maximums – whether for a number of days or visits, treatments or a yearly dollar limit – are subject to the Lifetime Maximum Benefit.		
Out-of-Pocket Limit		
Out-of-Pocket Limit Per Benefit Period	$6,500	$11,000
Aggregate Family Out-of-Pocket Limit Per Benefit Period	$13,000	$22,000
All Eligible Charges including Deductible apply towards the Out-of-Pocket Limit. Copayments do not apply towards the Out-of-Pocket Limit.		
All In-Network care must be received from a Network Provider.		

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Summary of Benefits ***Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance***	**In-Network**	**Out-of-Network**
Percentage Payable (Unless Otherwise Specified) All payments are based on Eligible Charges and negotiated fees.		
BCBSHP covers	70%	50%
The Member pays	30%	50%
The percentage BCBSHP covers after the Out-Of-Pocket Limit is met	100%	100%
Hospital Inpatient Services		
Room and Board (Semiprivate or ICU/CCU)	70%	50%
Hospital services and supplies (x-ray, lab, anesthesia, etc.)	70%	50%
Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	70%	50%
Pre-Admission Certification is required for all Hospital Admissions except for Medical Emergencies.		
Outpatient Hospital Services		
Outpatient Surgery, Facility, etc.	70%	50%
Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	70%	50%
Outpatient Diagnostics	70%	50%
Ambulatory Surgery Center	70%	50%
Outpatient Pre-certification required for specified procedures.		

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Summary of Benefits ***Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance***	**In-Network**	**Out-of-Network**
Accidental Injury or Medical Emergency $500 Copayment is waived if admitted to the Hospital.	$500 Copayment	$500 Copayment
Non-Accidental Injury or Non-Medical Emergency	70%	50%
Initial services rendered for the onset of symptoms for a life-threatening medical condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is 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 place his or her life in danger or serious harm.		
Professional Ambulance Service	70%	70%
Air Ambulance	70%	70%
Inpatient Mental Health Care and Substance Abuse Treatment 30 days per person per calendar year, combined, In-network and Out-of-network	70%	50%
Outpatient Mental Health Care and Substance Abuse Treatment 48 visits per person per calendar year, combined, In-network and Out-of-network	70%	50%
<u>Physician Office Services –</u> Office visits only, on an outpatient basis – including Preventive Care **First 3 visits** per member per calendar year	$30 Copayment	50%
After 3 visits For children through age 5, the deductible does NOT apply • Periodic Health Assessments • Developmental Assessment of the Child.	70% Deductible waived	50% Deductible waived
All other visits	70%	50%
<u>Preventive Care Services – children through age 5</u> • Age appropriate immunizations • Laboratory testing The Deductible does NOT apply for children through age 5 (In-network or Out-of-network).	70% Deductible waived	50% Deductible waived

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Summary of Benefits *Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance*	**In-Network**	**Out-of-Network**
Preventive Care Services – age 6 and older Services include, but are not limited to (Pap Smears, Chlamydia screenings, Ovarian Surveillance) • Mammography (not subject to Deductible)	100% Deductible waived	Not Covered
• Immunizations, PSA test, screenings performed in the office (not subject to Deductible)	70% Deductible waived	Not Covered
• Outpatient procedures-services include, but not limited to: colonoscopy	70%	Not Covered
Home Health Care Services 100 Home Health Care visits per person per benefit period, combined In-network and Out-of-network.	70%	50%
Skilled Nursing Facility 30 days per person per calendar year, combined In-and Out-of-Network	70%	50%
Hospice Care Services $10,000 Lifetime Maximum combined In-network and Out-of-network	70%	50%
Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers 30 visits per person, per calendar year, combined specialties combined In-network and Out-of-Network	70%	50%
Radiation Therapy / Chemotherapy	70%	50%
Speech Therapy 30 visits per person per calendar year, combined In-network and Out-of-Network	70%	50%
Respiratory Therapy 30 visits per person per calendar year, combined In-network and Out-of-network	70%	50%
Private Duty Nursing (RN or LPN) $2,500 per person per calendar year, combined In-network and Out-of-network	70%	50%
Wigs and Cranial Prosthetics		

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Summary of Benefits *Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance*	**In-Network**	**Out-of-Network**
$500 per person per calendar year, combined In-network and Out-of-network	70%	50%
Durable Medical Equipment	70%	50%
All other covered medical expenses	70%	50%

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Summary of Benefits ***Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance***	**In-Network**	**Out-of-Network**
Prescription Drug Benefits		
A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a Prescription Drug requires pre-authorization, please call Customer Service.		
Retail Pharmacy 34-day supply		
Tier 1 - Low cost or preferred medications. Generally generic.May include single source brand drugs, or multi-source brand drugs. Not subject to Deductible.	$15 Copayment	$15 Copayment
Tier 2 – Moderate cost, preferred medications. $500 deductible per person per calendar year. Generic required if available, not subject to Deductible. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance. May include generic, single source brand drugs or multi-source brand drugs.	$30 Copayment	$30 Copayment
Tier 3 – Non-preferred or high cost medications. $500 deductible per person per calendar year. Generic required if available, not subject to Deductible. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance. May include generic, single source brand drugs or multi-source brand drugs.	$60 Copayment	$60 Copayment
Tier 4 – Typically high-cost, injectable, infused, oral or inhaled medications. (Must use a Network Specialty Pharmacy. $500 deductible per person per calendar year. $4000 out-of-pocket maximum per person per year. Generic required if available. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance	40% Coinsurance	40% Coinsurance
Mail Order – Maintenance Only 90-day supply		
Tier 1 - Low cost or preferred medications. Generally generic.May include single source brand drugs, or multi-source brand drugs. Not subject to Deductible.	$30 Copayment	$30 Copayment
Tier 2 – Moderate cost, preferred medications. $500 deductible per person per calendar year. Generic required if available, not subject to Deductible. If brand name is selected, Member will pay the difference between the brand and generic	$75 Copayment	$75 Copayment

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Summary of Benefits *Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance*	In-Network	Out-of-Network
Eligible Charge plus any brand Copayment and Coinsurance. May include generic, single source brand drugs or multi-source brand drugs.		
Tier 3 – Non-preferred or high cost medications. $500 deductible per person per calendar year. Generic required if available, not subject to Deductible. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance. May include generic, single source brand drugs or multi-source brand drugs.	$150 Copayment	$150 Copayment
Tier 4 – Typically high-cost, injectable, infused, oral or inhaled medications. (Must use a Network Specialty Pharmacy. $500 deductible per person per calendar year. $4000 out-of-pocket maximum per person per year. Generic required if available. If brand name is selected, Member will pay the difference between the brand and generic Eligible Charge plus any brand Copayment and Coinsurance	40% Coinsurance	40% Coinsurance

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