

Summary of Benefits	In-Network	Out-of-Network
<p>This Summary of Benefits explains the extent to which Covered Services are available to covered persons on this Contract. Your Copayment, Coinsurance 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.</p>		
<p>Lifetime Maximums</p>		
<p>Lifetime Maximum Benefits All benefits combined: In-Network and Out-of-Network</p>	<p>\$7,000,000</p>	
<p>Lifetime Maximum Benefits for TMJ (included in total maximum) In-Network and Out-of-Network Combined</p>	<p>\$5,000</p>	
<p>Lifetime Maximum Benefits for Hospice Care (included in total maximum) In-Network and Out-of-Network Combined</p>	<p>\$10,000</p>	
<p>Calendar Year Deductibles All services are subject to a Deductible per Benefit Period unless otherwise stated. No benefits are payable until the Calendar Year Deductible is satisfied.</p>		
<p>Deductible</p> <p>Aggregate Deductible</p>	<p>\$750</p> <p>\$1,500</p>	<p>\$750</p> <p>\$1,500</p>
<p>Calendar Year Benefit Maximums All services and all calendar year maximums--whether for a number of days, or visits, treatments or yearly dollar limit--are subject to the Lifetime Maximum Benefit.</p>		
<p>Out-of-Pocket Limit</p>		
<p>Out-of-Pocket Limit Per Benefit Period</p> <p>Aggregate Out-of-Pocket Limit Per Benefit Period</p>	<p>\$3,750</p> <p>\$7,500</p>	<p>\$8,250</p> <p>\$16,500</p>
<p>All Eligible Charges including Deductible apply towards the Out-of-Pocket Limit.</p>		

Summary of Benefits	In-Network	Out-of-Network
<i>Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance</i>		
All In-Network care must be received from a Preferred Provider.		
Percentage Payable (Unless Otherwise Specified) All payments are based on Eligible Charges and negotiated fees. BCBSGA covers The Member pays The percentage BCBSGA covers after the Out-Of-Pocket Limit Is met	70% 30% 100%	60% 40% 100%
Hospital Inpatient Services Room and Board (Semiprivate or ICU/CCU) Hospital services and supplies (x-ray, lab, anesthesia, etc.) Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	70% 70% 70%	60% 60% 60%
Outpatient Hospital Services Outpatient Surgery, Facility, etc. Outpatient Physician Services (x-ray, surgeon, anesthesiologist, radiologist, pathologist, etc.) Outpatient Diagnostics Ambulatory Surgery Center Accidental Injury or Medical Emergency Non-Accidental Injury or Non-Medical Emergency	70% 70% 70% 70% 70% 70%	60% 60% 60% 60% 70% 60%

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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.		

Summary of Benefits <i>Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance</i>	In-Network	Out-of-Network
Professional Ambulance Service	70%	70%
Air Ambulance	70%	70%
Mental Health Care Inpatient Mental Health Care and Substance Abuse Treatment Days/Visits Maximum Per calendar year Percentage payable (Unless Otherwise Specified)	 30 70%	 30 60%
Outpatient Mental Health Care and Substance Abuse Treatment 48 visits per person per calendar year, combined In-Network and Out-of-Network Percentage payable (Unless Otherwise Specified)	 70%	 60%
Copayments		
Physician Office Services Copayment – Illness and Injury Unless specifically stated, all services obtained (e.g., lab tests, x-rays, immunizations etc.) are covered subject to your Deductible and Coinsurance. Surgical procedures performed in the office are covered subject to your Deductible and Coinsurance. Deductible does NOT apply to child wellness services for children through age 5. Deductible does not apply in-network First 3 visits per calendar year In-network not subject to Deductible After 3 visits benefits are payable subject to Deductible and Coinsurance	 \$30 copayment 70%	 60% after deductible 60% after deductible

Summary of Benefits <i>Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance</i>	In-Network	Out-of-Network
<p>Physician Office Services Copayment – Preventive Health Care</p> <p>First 3 visits per calendar year In-network not subject to Deductible</p> <p>After 3 visits benefits are payable subject to Deductible and Coinsurance</p> <p>Child Wellness Services for Members Age 5 and Under</p> <ul style="list-style-type: none"> • Periodic Health Assessments • Development assessment of the child • Age appropriate immunizations • Laboratory testing <p>The deductible does NOT apply to child wellness services for children through age 5 (in-network or out-of-network)</p> <p>Preventive Services for Members Over Age 5 Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Annual Gynecological Exam • Periodic Health Assessments • Immunizations • Flu Injections <p>Preventive Screenings for Females</p> <ul style="list-style-type: none"> • Mammography • Pap smear • Chlamydia Screening • Ovarian Surveillance • Colorectal Screening <p>Preventive Screenings for Males</p> <ul style="list-style-type: none"> • Prostate Screening • Colorectal Screening 	<p>\$30 copayment</p> <p>70%</p> <p>70%</p> <p>70%</p> <p>70%</p> <p>70%</p>	<p>60% after deductible</p> <p>60% after deductible</p> <p>60%</p> <p>60% after deductible</p> <p>60% after deductible</p> <p>60% after deductible</p>
<p>Home Health Care Services</p> <p>100Home Health Care visits per person per benefit</p>		

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period, combined In-Network and Out-of-Network	70%	60%
Skilled Nursing Facility 30 visits per person per calendar year, combined In-Network and Out-of-Network	70%	60%
Outpatient Pre-certification required for specified procedures		
Hospice Care Services \$10,000 Lifetime Maximum combined In-Network and Out-of-Network	70%	60%
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%	60%
Radiation Therapy/Chemotherapy	70%	60%
Respiratory Therapy 30 visits per person per calendar year, combined In-Network and Out-of-Network	70%	60%
Private Duty Nursing (RN or LPN) \$2,500 per person per calendar year, combined In-Network and Out-of-Network	70%	60%
Speech Therapy 30 visits per person per calendar year, combined In-Network and Out-of-Network	70%	60%

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Wigs and Cranial Prosthetics \$500 per calendar year, combined In-Network and Out-of-Network	70%	60%
Durable Medical Equipment	70%	60%
All Other Covered Medical Expenses	70%	60%

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<p align="center">Prescription Drug Benefits</p>		
<p>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 drug requires pre-authorization, please call Customer Service.</p>		
<p>Retail Pharmacy 34-day supply</p> <p>Outpatient Prescription Drugs-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 copayment and coinsurance</p> <p>Brand and Specialty Outpatient Prescription Drugs \$250 deductible per person per calendar year for brand and specialty drugs combined up to an out-of-pocket maximum of \$300 per script and \$4,000 annual out-of-pocket maximum per person</p> <p>Mail Order Drugs (Maintenance Only) 90-day supply</p> <p>Outpatient Prescription Drugs-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 copayment and coinsurance</p> <p>Brand and Specialty Outpatient Prescription Drugs \$250 deductible per person per calendar year for brand and specialty drugs combined up to an out-of-pocket maximum of \$300 per script and \$4,000 annual out-of-pocket maximum per person</p>	<p align="center">Greater of \$15 Copayment OR 40% Coinsurance</p> <p align="center">Greater of \$15 Copayment OR 40% Coinsurance</p> <p align="center">Greater of \$15 Copayment OR 40% Coinsurance</p> <p align="center">Greater of \$15 Copayment OR 40% Coinsurance</p>	<p align="center">Greater of \$15 Copayment OR 40% Coinsurance</p> <p align="center">Greater of \$15 Copayment OR 40% Coinsurance</p> <p align="center">Greater of \$15 Copayment OR 40% Coinsurance</p> <p align="center">Greater of \$15 Copayment OR 40% Coinsurance</p>

Verification of Benefits

Verification of Benefits is available for Members or authorized healthcare providers on behalf of Members. You may call Customer Service with a **benefits inquiry** or **Verification of Benefits** during normal business hours. Please remember that a **benefits inquiry** or **Verification of Benefits** is Not a Verification of Coverage of a specific medical procedure.

- **Verification of Benefits is NOT a guarantee of payment.**
- **If the verified service requires pre-certification, please call 1-800-722-6614.**

Pre-Admission Certification(PAC)Required

- Required for ALL Hospital admissions except emergency or maternity delivery admissions. Please notify BCBSGA within 48 hours of an emergency or maternity admission.
- Pre-Admission Certification determinations are available by phone through BCBSGA's pre-certification staff 24 hours a day, seven days a week for urgent/non-elective care that must be performed within 24 hours after the PAC request, without which a significant threat to the patient's health or well-being will be posed.
- Non-urgent/elective pre-certification can be requested during normal business hours.
- The phone number for pre-certification is **1-800-722-6614**.
- Emergency services do **NOT** require pre-certification.

PAC is a guarantee of payment as described in this section (and BCBSGA will cover up to the reimbursement level of this Contract when the Covered Services are performed within the time limits assigned by PAC) **except for the following situations:**

- The Member is no longer covered under this Contract at the time the services are received;
- The benefits under this Contract have been exhausted (examples of this include day limits or maximum amounts);
- No benefits will be paid in cases of fraud.

Pre-certification approvals apply only to services which have been approved in the pre-certification process and only as described in the approval. Such approval does not apply to any other services. Payment or authorization of such a service does not require or apply to payment of claims at a later date regardless of whether such later claims have the same, similar or related diagnoses.

NOTICE:

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based his or her status as a victim of family violence.