

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.		
<p>Percentage Payable (Unless Otherwise Specified) All payments are based on Eligible Charges and negotiated fees.</p> <p>BCBSGA covers</p> <p>The Member pays</p> <p>The percentage BCBSGA covers after the Out-Of-Pocket Limit Is met</p>	<p>70%</p> <p>30%</p> <p>100%</p>	<p>60%</p> <p>40%</p> <p>100%</p>
<p>Hospital Inpatient Services</p> <p>Room and Board (Semiprivate or ICU/CCU)</p> <p>Hospital services and supplies (x-ray, lab, anesthesia, etc.)</p> <p>Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.)</p>	<p>70%</p> <p>70%</p> <p>70%</p>	<p>60%</p> <p>60%</p> <p>60%</p>
<p>Outpatient Hospital Services</p> <p>Outpatient Surgery, Facility, etc.</p> <p>Outpatient Physician Services (x-ray, surgeon, anesthesiologist, radiologist, pathologist, etc.)</p> <p>Outpatient Diagnostics</p> <p>Ambulatory Surgery Center</p> <p>Accidental Injury or Medical Emergency</p> <p>Non-Accidental Injury or Non-Medical Emergency</p>	<p>70%</p> <p>70%</p> <p>70%</p> <p>70%</p> <p>70%</p> <p>70%</p> <p>70%</p>	<p>60%</p> <p>60%</p> <p>60%</p> <p>60%</p> <p>70%</p> <p>60%</p>

Summary of Benefits	In-Network	Out-of-Network
<i>Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance</i>		
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>Child Wellness Services for Members Age 5 and Under</p> <p>First 3 visits per calendar year In-network or Out-of-network not subject to Deductible</p> <p>After 3 visits benefits are payable subject to Deductible and Coinsurance</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</p> <p>First 3 visits per calendar year</p> <p>After 3 visits benefits are payable subject to Deductible and Coinsurance</p> <p>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>\$30</p> <p>70%</p> <p>70%</p> <p>70%</p> <p>\$30</p> <p>70%</p> <p>70%</p> <p>70%</p> <p>70%</p>	<p>60%</p> <p>60%</p> <p>60%</p> <p>60%</p> <p>60%</p> <p>60%</p> <p>60%</p> <p>60%</p> <p>60%</p>

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Preventive Screenings for Males <ul style="list-style-type: none"> • Prostate Screening • Colorectal Screening 	70%	60%
Home Health Care Services 100 Home Health Care visits per person per benefit 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 only, not subject to Deductible</p> <p>This policy only covers insulin and generic prescription drugs. We do not cover brand prescription drugs even when generic prescription drugs are not available. In the event no generic version is available, Member will pay BCBSGA negotiated amount or Eligible Charge for the brand prescription drug when using an In-Network pharmacy</p> <p>Mail Order Drugs (Maintenance Only) 90-day supply</p> <p>Outpatient Prescription Drugs - Generic only, not subject to Deductible</p> <p>This policy only covers insulin and generic prescription drugs. We do not cover brand prescription drugs even when generic prescription drugs are not available. In the event no generic version is available, Member will pay BCBSGA negotiated amount or Eligible Charge for the brand prescription drug when using an In-Network pharmacy.</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>