

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, 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.</p>		
<p>Lifetime Maximums</p>		
<p>Lifetime Maximum Benefits All benefits combined: In-Network and Out-of-Network</p>	<p>\$5,000,000</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 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.</p>		
<p>Deductible Aggregate Deductible</p>	<p>\$7,500 \$15,000</p>	<p>\$7,500 \$15,000</p>
<p>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.</p>		
<p>Out-of-Pocket Limit</p>		
<p>Out-of-Pocket Limit Per Benefit Period</p>	<p>\$10,500</p>	<p>\$15,000</p>
<p>Aggregate Family Out-of-Pocket Limit Per Benefit Period</p>	<p>\$21,000</p>	<p>\$30,000</p>
<p>All Eligible Charges including Deductible apply towards the Out-of-Pocket Limit. Copayments do not apply towards the Out-of-Pocket Limit.</p>		
<p>All In-Network care must be received from a Network Provider.</p>		

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

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Accidental Injury or Medical Emergency \$500 Copayment is waived if admitted to the Hospital. Non-Accidental Injury or Non-Medical Emergency	\$500 Copayment 70%	\$500 Copayment 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%
<p><u>Physician Office Services – Office visits only, on an outpatient basis – including Preventive Care</u></p> <p>First 3 visits per member per calendar year</p> <p>After 3 visits For children through age 5, the deductible does NOT apply</p> <ul style="list-style-type: none"> • Periodic Health Assessments • Developmental Assessment of the Child. <p>All other visits</p> <p><u>Preventive Care Services – children through age 5</u></p> <ul style="list-style-type: none"> • Age appropriate immunizations • Laboratory testing <p>The Deductible does NOT apply for children through age 5 (In-network or Out-of-network).</p>	\$30 Copayment 70% Deductible waived 70% 70% Deductible waived	50% 50% Deductible waived 50% 50% Deductible waived

Summary of Benefits <i>Unless Specifically Stated, All Services Are Subject To The Deductible And Coinsurance</i>	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) <ul style="list-style-type: none"> • Mammography (not subject to Deductible) • Immunizations, PSA test, screenings performed in the office (not subject to Deductible) • Outpatient procedures-services include, but not limited to: colonoscopy 	100% Deductible waived	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		

