

Summary of Benefits	In-Network	Out-of-Network
<i>All In-Network care must be received from a Preferred Provider</i>		
Lifetime Medical Maximum Benefit All In-Network and Out-of-Network Benefits Combined	\$5,000,000	
Lifetime Maximum Benefit for Hospice Care (included in total maximum) In-Network and Out-of-Network Combined	\$10,000	
Calendar Year Deductible In-Network and Out-of-Network Combined	\$3,000	
Percentage Payable (Unless Otherwise Specified) Plan Pays Member Pays Percentage Payable after the Out-of-Pocket Maximum is met	100% 0% 100%	70% 30% 100%
<i>Unless otherwise specified, no benefits are payable until the Calendar Year Deductible is satisfied.</i>		
Out-of-Pocket Maximum Per Calendar Year (For out-of-network services, this amount is in addition to the Deductible and Copayment) In-Network and Out-of-Network Amounts Combined	\$3,000	\$10,000
Inpatient Hospital Services Room and Board, Hospital services and supplies (Pre-certification Required for all inpatient stays)	100%	Plan pays \$650 per day toward Eligible Charges
Outpatient Hospital Services / Ambulatory Surgical Center (Outpatient Pre-certification required for specified procedures)	100%	Plan pays \$380 per day toward Eligible Charges
Professional Services As outlined in the Benefits Section of this Contract	100%	70% of Eligible Charges, subject to balance billing
Accidental Injury or Medical Emergency Emergency Room Copayment <i>Not subject to the Calendar Year Deductible</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. The emergency room Copayment is waived if admitted to the Hospital.	\$100	\$100 Plus all charges in excess of Eligible Charges

Summary of Benefits	In-Network	Out-of-Network
<p>Office Visits</p>	<p>\$30 Copayment for the first 4 office visits in a Calendar Year.</p> <p>Subscriber pays negotiated fee rate until the Calendar Year Deductible is met.</p> <p>Once the Calendar Year Deductible is met, benefits are payable at 100% with no Copayment.</p>	<p>70% of Eligible Charges for the first 4 office visits in a Calendar Year – not subject to the deductible (subject to balance billing).</p> <p>Subscriber pays all charges for subsequent office visits until the Calendar Year Deductible is met.</p> <p>Once the Calendar Year Deductible is met, the plan pays 70% of Eligible Charges, subject to balance billing.</p>
<p>Professional Ambulance Service – Covered when Medically Necessary and rendered by a state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.</p> <p>Land Ambulance</p> <p>Air Ambulance</p>	<p>\$1,000 per trip maximum</p> <p>\$5,000 per trip maximum</p>	<p>\$1,000 per trip maximum</p> <p>\$5,000 per trip maximum</p>
<p>Mental Health Care and Substance Abuse Treatment – Hospital Services</p> <p>Maximum payment per day toward Eligible Charges</p> <p>Calendar Year maximum benefit (In- and Out-of-Network Combined)</p>	<p>\$100</p> <p>\$3,000</p>	<p>\$100</p> <p>\$3,000</p>
<p>Mental Health Care and Substance Abuse Treatment – In or Outpatient Professional Charges</p> <p>Per visit maximum toward Eligible Charges</p> <p>Calendar Year visit maximum (In- and Out-of-Network Combined)</p>	<p>\$30</p> <p>12</p>	<p>\$30</p> <p>12</p>

Summary of Benefits	In-Network	Out-of-Network
Vision Services Maximum benefit per Calendar Year (not subject to the Calendar Year Deductible)	\$50	\$50
Dental Injury Services of a Physician or dentist treating an accidental injury to natural teeth or structure occurring while a Member is covered by this Contract and when services are performed within 180 days of the date of accident.	100%	Plan pays 70% of Eligible Charges, subject to balance billing.
Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers Plan pays Visit Maximum per Calendar Year, In-Network and Out-of-Network combined Visit Maximum for treatment of the following diagnoses, In-Network and Out-of-Network combined: <ul style="list-style-type: none"> • Post neurological surgery • Orthopedic surgery • Cerebral vascular accident (stroke) • Third degree burns • Head trauma • Spinal Cord Injury 	100% 12 24	\$25 per visit of Eligible Charges 12 24
Speech Therapy Maximum visit per Calendar Year following surgery, injury or non-congenital organic disease	100% 50	70% of Eligible Charges, subject to balance billing. 50
TMJ Lifetime Maximum Benefit of \$5,000	100%	70% of Eligible Charges, subject to balance billing.
Smoking Cessation Lifetime Maximum benefit for any smoking cessation program	\$50	\$50
Home Health Care Services Visit Maximum per Calendar Year, In-Network and Out-of-Network combined	100% 60	\$75 payable per visit toward Eligible Charges 60
Skilled Nursing Facility Care Visit Maximum per Calendar Year, In-Network and Out-of-Network combined	100% 100	\$150 payable per day toward Eligible Charges 100

Summary of Benefits	In-Network	Out-of-Network
<p>Infusion Services</p>	<p>100%</p>	<p>Plan pays \$50 per day toward Eligible Expenses for Administration and Professional Services</p> <p>Subscriber pays all charges in excess of the Average Wholesale Price (AWP) of the Drug.</p> <p>\$500 per day Combined maximum payable for professional and drugs combined</p>
<p>Contraception Oral contraceptive generic drugs prescribed for birth control and FDA approved prescription devices are covered.</p>	<p>\$10 copayment</p>	<p>\$10 copayment</p>
<p>Generic Prescription Drugs</p>	<p>Lesser of cost or \$10 copayment</p>	<p>Lesser of cost or \$10 copayment</p>
<p>Brand Name Drugs – \$2,000 Brand Prescription Drug Deductible per Calendar Year applies in addition to the Medical Calendar Year Deductible.</p> <p>Brand Name Preferred Drug</p> <p>Brand Name Non-Preferred Drug</p> <p>Self-Administered Injectable Drugs (except insulin)</p>	<p>\$30 Copayment</p> <p>\$50 Copayment</p> <p>Subscriber pays 30% of the Negotiated Fee</p>	<p>\$30 Copayment</p> <p>\$50 Copayment</p> <p>Subscriber pays 30% of the Negotiated Fee</p>
<p>Mail Order Pharmacy</p> <p>Generic</p>	<p>\$10 Copayment for each 30-day supply</p> <p>\$20 Copayment for each 60-day supply</p>	<p>\$10 Copayment for each 30-day supply</p> <p>\$20 Copayment for each 60-day supply</p>

Exclusions and Limitations

Benefits are not provided for:

1. No maternity benefits are payable under this contract.
2. Care, supplies or equipment not Medically Necessary, as determined by BCBSGA, for the treatment of an Injury or illness.
3. Any item, service, supply or care not specifically listed as a Covered Service in this Contract.
4. Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends. (Such a requirement shall not prejudice an existing claim.) Such services and supplies shall include, but not be limited to, Inpatient Hospital Admissions which begin before a Member's Effective Date.
5. Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
6. Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
7. Any portion of a provider's fee or charge which is ordinarily due from a Member but which has been waived. If a provider routinely waives (does not require the Member to pay) a Deductible or Out-of-Pocket amount, BCBSGA will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
8. Care for any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.
9. Any disease or injury resulting from a war, declared or not, or any military duty, or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities as required by law.
10. Care given by a medical department or clinic run by your employer.
11. Admission or continued Hospital or skilled nursing facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
12. Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
13. Preventative care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
14. Daily room charges while the Contract is paying for an intensive care, cardiac care, or other special care unit.
15. Vision care services and supplies, including but not limited to eyeglasses, contact lenses, hearing aids, hearing devices and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service.
16. Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Contract.
17. The following items related to Durable Medical Equipment:
 - Air conditioners, humidifiers, dehumidifiers, or purifiers;
 - Arch supports, orthopedic or corrective shoes;
 - Heating pads, hot water bottles, home enema equipment or rubber gloves;
 - Sterile water;
 - Deluxe equipment, such as motor driven chairs or beds, when standard equipment is adequate;
 - Rental or purchase of equipment if you are in a facility which provides such equipment;
 - Electric stair chairs or elevator chairs;
 - Physical fitness, exercise, or ultraviolet/tanning equipment;
 - Residential structural modification to facilitate the use of equipment;
 - Other items of equipment which BCBSGA feels do not meet the listed criteria.
18. The following items related to prosthetic devices: corrective shoes; dentures, replacing teeth or structures directly supporting teeth, except to correct traumatic injuries, electrical or magnetic

