Blue Cross and Blue Shield of Georgia (BCBSGA)
PREMIER WITH MATERNITY – SUMMARY OF BENEFITS

This **Summary** provides an overview of benefits and is not a complete explanation of these benefits. To understand them, please refer to the Contract. All Covered Services shall be provided subject to all terms and conditions stated in the Contract.

Calendar Year Deductibles – All services are subject to a Deductible per Calendar Year unless otherwise stated. No benefits are payable until the Calendar Year Deductible is satisfied. **This summary applies to the Premier product with deductible options of $10,000 and $20,000.**

	In-Network	Out-of-Network
Lifetime 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.		
Lifetime Maximum Benefits **All benefits combined:** In and Out-of-Network	$7,000,000	
Lifetime Maximum Benefits for TMJ (included in total maximum) In and Out-of-Network Combined	$5,000	
Lifetime Maximum Benefits for Hospice Care (included in total maximum) In and Out-of-Network Combined	$10,000	
Out-of-Pocket Limit All Eligible Charges including Deductible apply towards the Out-of-Pocket Limit.		
Individual - Per Benefit Period **Aggregate - Per Benefit Period**	Deductible only	Deductible + $6,500 Deductible + $10,000
All In-Network care must be received from a Preferred Provider.		

Covered Services ***Unless specifically stated, all services are subject to deductible and coinsurance***	**In-Network**	**Out-of-Network**
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	 100% 0% 100%	 70% 30% 100%
Physician Office Visit Copayment – Including Preventive Visits 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.	$35 Copayment	70%
Child Wellness Services for Members Age 5 and Under: The deductible does NOT apply for in or out-of-network services • Periodic Health Assessments • Development assessment of the child • Age appropriate immunizations • Laboratory testing **Preventive Services for Members Over Age 5:** The deductible does NOT apply for in-network services Services include, but are not limited to: • Periodic Health Assessments • Immunizations • Flu Injections • Chlamydia Screening • Colorectal Screening, including colonoscopy • Annual Gynecological Exam • Mammography • Pap smear • Ovarian Surveillance • Preventive Screenings for Males, including Prostate Screening	80%, not subject to deductible 80%, not subject to deductible	60%, not subject to deductible 60%

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Covered Services ***Unless specifically stated, all services are subject to deductible and coinsurance***	**In-Network**	**Out-of-Network**
Hospital Inpatient Services		
• Room and Board (Semi-private or ICU/CCU)	100%	70%
• Hospital services and supplies (x-ray, lab, anesthesia, etc.)	100%	70%
• Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	100%	70%
Outpatient Hospital Services - Outpatient Surgery, Facility, etc.		
• Outpatient Physician Services (x-ray, surgeon, anesthesiologist, radiologist, pathologist, etc.)	100%	70%
• Outpatient Diagnostics	100%	70%
• Ambulatory Surgery Center	100%	70%
Accidental Injury or Medical Emergency Initial services rendered for the onset of symptoms for a life-threatening medical condition or serious Accidental Injury which requires immediate medical care.	100%	100%
Non-Accidental Injury or Non-Medical Emergency	100%	70%
Maternity Services		
• Physician care	100%	70%
• Hospital Facility	$3,000 copayment	70%
Complications of Pregnancy Conditions of sufficient severity that the absence of immediate medical attention could be reasonably expected to result in a threat to life (immediate or delayed).	100%	70%
Professional Ambulance Service, including Air Ambulance	100%	70%
Inpatient Mental Health Care and Substance Abuse Treatment 30 days per person per calendar year, combined In and Out-of-Network	100%	70%
Outpatient Mental Health Care and Substance Abuse Treatment 48 visits per person per calendar year, combined In and Out-of-Network	100%	70%
Home Health Care Services 100 visits per person per calendar year, combined In and Out-of-Network	100%	70%
Skilled Nursing Facility 30 days per person per calendar year, combined In and Out-of-Network	100%	70%
Hospice Care Services $10,000 Lifetime Maximum combined In and Out-of-Network	100%	70%
Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers 30 visits per person per calendar year, combined specialties, combined In and Out-of-Network	100%	70%
Radiation Therapy/Chemotherapy	100%	70%
Respiratory Therapy 30 visits per person per calendar year, combined In and Out-of-Network	100%	70%
Private Duty Nursing (RN or LPN) $2,500 per person per calendar year, combined In and Out-of-Network	100%	70%
Speech Therapy 30 visits per person per calendar year, combined In and Out-of-Network	100%	70%
Wigs and Cranial Prosthetics $500 per calendar year, combined In and Out-of-Network	100%	70%
Durable Medical Equipment	100%	70%
Vision Eye Examination Limited to one exam per person every 12 months.	$10	70%
All Other Covered Medical Expenses	100%	70%
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 drug requires pre-authorization, please call Customer Service.		

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Retail Pharmacy - 34-day supply **Mail Order Drugs Maintenance Only** - 90-day supply		
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	Greater of $15 Copayment **OR** 40% Coinsurance	Greater of $15 Copayment **OR** 40% Coinsurance
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	Greater of $15 Copayment **OR** 40% Coinsurance	Greater of $15 Copayment **OR** 40% Coinsurance

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