

**Blue Cross and Blue Shield of Georgia (BCBSGA)
SMARTSENSE WITH COMPREHENSIVE DRUG – SUMMARY OF BENEFITS**

Covered Services <i>Unless specifically stated, all services are subject to deductible and coinsurance</i>	In-Network	Out-of-Network
Hospital Inpatient Services <ul style="list-style-type: none"> Room and Board (Semi-private or ICU/CCU) Hospital services and supplies (x-ray, lab, anesthesia, etc.) Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) 	70%	60%
Outpatient Hospital Services - Outpatient Surgery, Facility, etc. <ul style="list-style-type: none"> Outpatient Physician Services (x-ray, surgeon, anesthesiologist, radiologist, pathologist, etc.) Outpatient Diagnostics Ambulatory Surgery Center 	70%	60%
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.	70%	60%
Non-Accidental Injury or Non-Medical Emergency	70%	60%
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).	70%	60%
Professional Ambulance Service, including Air Ambulance	70%	70%
Inpatient Mental Health Care and Substance Abuse Treatment 30 days per person per calendar year, combined In and Out-of-Network	70%	60%
Outpatient Mental Health Care and Substance Abuse Treatment 48 visits per person per calendar year, combined In and Out-of-Network	70%	60%
Home Health Care Services 100 visits per person per calendar year, combined In and Out-of-Network	70%	60%
Skilled Nursing Facility 30 days per person per calendar year, combined In and Out-of-Network	70%	60%
Hospice Care Services \$10,000 Lifetime Maximum combined In 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 and Out-of-Network	70%	60%
Radiation Therapy/Chemotherapy	70%	60%
Respiratory Therapy 30 visits per person per calendar year, combined In and Out-of-Network	70%	60%
Private Duty Nursing (RN or LPN) \$2,500 per person per calendar year, combined In and Out-of-Network	70%	60%
Speech Therapy 30 visits per person per calendar year, combined In and Out-of-Network	70%	60%
Wigs and Cranial Prosthetics \$500 per calendar year, combined In and Out-of-Network	70%	60%
Durable Medical Equipment	70%	60%
All Other Covered Medical Expenses	70%	60%
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.		
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 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	Greater of \$15 Copayment OR 40% Coinsurance Greater of \$15 Copayment OR 40% Coinsurance