

**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 \$750, \$1,500, \$2,500, and \$5,000.**

	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	Deductible + \$2,500	Deductible + \$6,500
Aggregate - Per Benefit Period	Deductible + \$5,000	Deductible + \$10,000
All In-Network care must be received from a Preferred Provider.		

Covered Services <i>Unless specifically stated, all services are subject to deductible and coinsurance</i>	In-Network	Out-of-Network
Percentage Payable (Unless Otherwise Specified) All payments are based on Eligible Charges and negotiated fees. <ul style="list-style-type: none"> BCBSGA covers The Member pays The percentage BCBSGA covers after the Out-Of-Pocket Limit is met 	80% 20% 100%	60% 40% 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	60%
Child Wellness Services for Members Age 5 and Under: The deductible does NOT apply for in or out-of-network services <ul style="list-style-type: none"> Periodic Health Assessments Development assessment of the child Age appropriate immunizations Laboratory testing 	80%, not subject to deductible	60%, not subject to deductible
Preventive Services for Members Over Age 5: The deductible does NOT apply for in-network services Services include, but are not limited to: <ul style="list-style-type: none"> 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	60%

