

Premier Select \$25 \$1000/80%/60%

SCHEDULE OF BENEFITS

BENEFITS	MEMBER PAYS	
	In Network	Out of Network
Annual Deductible	Individual: \$1,000 Family: \$3,000	Individual: \$1,000 Family: \$3,000
Annual Out-of-Pocket Maximum	Individual: \$3,000 Family: \$9,000	Individual: \$3,000 Family: \$9,000
Lifetime Maximum Benefit (per Member)	Unlimited	Unlimited
PRIMARY CARE PHYSICIAN (PCP) SERVICES - When performed and billed in physician office		
Office Visit	\$25	Ded + 40%
Allergy Testing, Treatment and Injections	\$25	Ded + 40%
Annual Adult Physical	\$25	Ded + 40%
Annual Well-Woman Exam	\$25	Ded + 40%
Cancer Screenings	\$25	Ded + 40%
Chemotherapy and Radiation	\$25	Ded + 40%
Child Wellness Care	\$25	40%
Family Planning	\$25	Ded + 40%
Immunizations, Vaccines and Infusions	\$25	Ded + 40%
Laboratory Services - When specimen is drawn in physician office	\$25	Ded + 40%
Radiology - When test is performed in physician office	\$25	Ded + 40%
SPECIALIST PHYSICIAN SERVICES - When performed and billed in physician office		
Office Visit	\$25	Ded + 40%
Allergy Testing, Treatment and Injections	\$25	Ded + 40%
Annual Adult Physical	\$25	Ded + 40%
Annual Well-Woman Exam	\$25	Ded + 40%
Cancer Screenings	\$25	Ded + 40%
Chemotherapy and Radiation	\$25	Ded + 40%
Family Planning	\$25	Ded + 40%
Immunizations, Vaccines and Infusions	\$25	Ded + 40%
Laboratory Services - When specimen is drawn in physician office	\$25	Ded + 40%
Radiology - When test is performed in physician office	\$25	Ded + 40%
PHYSICIAN SERVICES - When performed and billed in physician office		
MRIs and MRAs	Ded + 20%	Ded + 40%
Nuclear Stress Tests	Ded + 20%	Ded + 40%
INPATIENT HOSPITAL SERVICES		
Inpatient Hospital Care	Ded + 20%	Ded + 40%
Inpatient Rehabilitation Facility	Ded + 20%	Ded + 40%
Physician Services	Ded + 20%	Ded + 40%
MATERNITY SERVICES		
Physician Services - One-time copayment per pregnancy (for In-Network services)	One-Time \$25 Copay	Ded + 40%
Inpatient Maternity Care	Ded + 20%	Ded + 40%
THERAPY SERVICES - OUTPATIENT		
Cardiac Rehabilitation Therapy - Limited to 30 visits annually	\$25	Ded + 40%
Pulmonary Rehabilitation Therapy - Limited to 30 visits annually	\$25	Ded + 40%
Physical and Occupational Therapies - Limited to 20 visits annually (combined)	\$25	Ded + 40%
Speech Therapy - Limited to 20 visits annually	\$25	Ded + 40%
URGENT AND EMERGENCY SERVICES		
Urgent Care in Urgent Care Facility	\$75	\$75
Emergency Services - Copay waived if admitted to hospital	\$200	\$200
Ambulance	\$200	\$200
OUTPATIENT SERVICES - When performed and billed in outpatient facility		
Mammograms	No Copay, Coins or Ded	Ded + 40%
Advanced Imaging, including:		
-- MRIs and MRAs	Ded + 20%	Ded + 40%
-- CAT Scans	Ded + 20%	Ded + 40%
-- PET Scans	Ded + 20%	Ded + 40%
-- Nuclear Stress Tests	Ded + 20%	Ded + 40%
Ambulatory Surgery	Ded + 20%	Ded + 40%
Cancer Screenings	Ded + 20%	Ded + 40%
Chemotherapy and Radiation Services	Ded + 20%	Ded + 40%
Dialysis	Ded + 20%	Ded + 40%
Family Planning	Ded + 20%	Ded + 40%
Laboratory Services - When specimen is drawn in outpatient facility	Ded + 20%	Ded + 40%
Radiology - When test is performed in outpatient facility	Ded + 20%	Ded + 40%
OTHER SERVICES		
Convenience Clinic Care	\$25	\$25
Durable Medical Equipment (DME) - Coinsurance does not apply to Out-of-Pocket Maximum	50%	50%
Orthotics - Coinsurance does not apply to Out-of-Pocket Maximum	50%	50%
Prosthetics - Coinsurance does not apply to Out-of-Pocket Maximum	50%	50%
Home Health Care - Limited to 60 visits annually	Ded + 20%	Ded + 40%
Hospice	Ded + 20%	Ded + 40%
Skilled Nursing Facility - Limited to 60 days annually	Ded + 20%	Ded + 40%
Infertility Services - Limited to \$1,500 annual benefit maximum	No Copay, Coins or Ded	Ded + 40%

This Schedule of Benefits is part of your Certificate of Coverage but does not replace it. Many words are defined elsewhere in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Certificate. A complete list of covered services, exclusions, and limitations can be found in your Certificate of Coverage.

Prior authorization may be required for specific services.

- Coinsurance applies to Out-of-Pocket Maximum, *except* for DME, Orthotics and Prosthetics.
- Deductible does not apply to Out-of-Pocket Maximum.
- All visit and day limits are counted by combining In-Network and Out-of-Network services.

Important note about Out-of-Network services:

Payment to Out-of-Network providers is based on the Out-of-Network Rate (ONR). The ONR is determined by a percentage of Medicare. Please see your Certificate of Coverage for more information on ONR.



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