

BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
DEDUCTIBLE	\$1,500 per calendar Year.		
LIFETIME MEDICAL BENEFIT MAXIMUM	\$5,000,000 lifetime maximum benefits paid by BC Life.		
OUT-OF-POCKET MAXIMUM	\$1,500 Deductible per calendar Year, Participating and Non-Participating Providers combined.	\$10,000 per calendar Year.	
OFFICE VISITS	You pay a \$40 Copayment per Office Visit.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	<p>No Deductible is required for Office Visits.</p> <p>Covered Services, including routine physical exams, preventive care and professional services, that you receive in your Physician's office during the Office Visit are covered under this benefit.</p> <p>Copayments/Coinsurance amounts will not be applied to the Deductible or out-of-pocket maximum, and you will continue to be required to pay Copayments/Coinsurance after your Deductible and out-of-pocket maximum have been satisfied.</p>
PROFESSIONAL SERVICES	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	<p>This benefit is separate from professional services covered under the Office Visit benefit (see above).</p> <p>Refer to the section PROFESSIONAL SERVICES under the PART called WHAT IS COVERED for a detailed description of Covered Services.</p>

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<p>EMERGENCY ROOM</p>	<p>You pay a \$100 Copayment for each emergency room visit.</p> <p>This Copayment covers the emergency room visit and Covered Services that you receive in the emergency room during that visit.</p>	<p>You pay a \$100 Copayment plus all charges in excess of Covered Expense for each emergency room visit.</p> <p>This benefit covers the emergency room visit and Covered Services that you receive in the emergency room during that visit.</p>	<p>No Deductible is required.</p> <p>Your \$100 Copayment is waived if the emergency room visit results in an inpatient admission into a Hospital immediately following the emergency room services.</p> <p>Copayments/Coinsurance amounts will not be applied to the Deductible or out-of-pocket maximum, and you will continue to be responsible for payment after your Deductible and out-of-pocket maximum have been satisfied.</p>
<p>INPATIENT HOSPITAL</p>	<p>You do not pay any Coinsurance.</p>	<p>You pay all charges except \$650 per day.</p>	<p>A Center of Expertise (COE) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only when performed by a Participating Provider at an approved COE facility, except for Medical Emergencies. For more information, please see the section entitled CENTERS OF EXPERTISE (COE) FOR TRANSPLANTS AND BARIATRIC SURGERY under the PART called WHAT IS COVERED.</p> <p>Does not include treatment for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).</p>
<p>OUTPATIENT HOSPITAL AMBULATORY SURGICAL CENTER</p>	<p>You do not pay any Coinsurance.</p>	<p>You pay all charges except \$380 per day.</p>	<p>Does not include treatment for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).</p>
<p>VISION</p>	<p>You pay all charges except \$50 per calendar Year.</p>		<p>No Deductible is required.</p> <p>Covered Services received under this benefit are separate from Covered Services received under any other benefit described in this Policy.</p> <p>For a description of Covered Services, please see the VISION section in the PART called WHAT IS COVERED. For additional benefits, please see the vision section.</p>

