



Blue Value POS – Small Group Plan 2010SX Benefit Summary

In addition to copayments, members are responsible for deductibles, as described below.
Please review the deductible information to know if a deductible applies to a specific covered service.
Members are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in *italics*.

When using out-of-network providers, members are responsible for any difference between the allowed amount & actual charges, as well as any copayments and deductibles.

Deductibles, Maximums, etc.	In-Network Benefit Level	Out-of-Network Benefit Level
Calendar Year Deductible: <i>one for employee, one for spouse, one for all eligible children combined</i>		
– Individual	\$1,000	\$2,000
– Family	\$3,000	\$6,000
Coinsurance	Plan pays 100% after deductible	Plan pays 60% after deductible Member pays 40% after deductible
Lifetime Maximum	Unlimited	\$5,000,000
Out-of-Pocket Calendar Year Maximum*		
– Individual	None	\$4,000
– Family	None	\$12,000

* *Maximum of three (3) per family* (one for employee, one for spouse and one for all eligible children combined). The following do not apply to out-of-pocket maximum: deductibles, copayment amounts, non-emergency room copayments, non-covered items and coinsurance for mental health/substance abuse. Out-of-Pocket limits are accumulated separately for in-network and out-of-network services.

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Office Visits: Preventive Care		
• Well-child care, immunizations	\$25 copayment	Plan pays 60% after deductible <i>(deductible waived through age 5)</i>
• Periodic health examinations	\$25 copayment	Not covered
• Annual gynecology examination (No PCP referral required)	\$25 copayment	Plan pays 60% after deductible
• Prostate screening	\$25 copayment	Plan pays 60% after deductible
Illness or Injury		
• Primary Care Physician (PCP) office visit (includes lab, radiology, and office surgery)	\$25 copayment	Plan pays 60% after deductible
• Primary care physician after hours visit	\$30 copayment	Plan pays 60% after deductible
• Specialty care physician office visit (PCP referral required)	\$25 copayment	Plan pays 60% after deductible
• Second surgical opinion (PCP referral required)	\$25 copayment	Plan pays 60% after deductible
• Allergy care (office visit, testing, serum, and allergy shots)	\$25 copayment	Plan pays 60% after deductible
• Maternity physician services (prenatal, delivery, postpartum)	\$100 copayment <i>(first office visit only)</i>	Plan pays 60% after deductible
• Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions (No PCP referral required)	\$25 copayment	Plan pays 60% after deductible
• Services provided by network dermatologists (No PCP referral required)	\$25 copayment	Plan pays 60% after deductible
Emergency Room Services		
• Life-threatening illness, serious accidental injury or with a PCP referral	\$100 copayment <i>(waived if admitted)</i>	\$100 copayment <i>(waived if admitted)</i>
• Non-emergency use of the emergency room	Not covered	Not covered

Covered Services	In-Network Benefit Level	Out-of-Network Benefit Level
Inpatient Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Plan pays 100% after deductible	Plan pays 60% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100% after deductible	Plan pays 60% after deductible
Outpatient Services		
• Surgery facility/hospital charges	Plan pays 100% after deductible	Plan pays 60% after deductible
• Diagnostic X-ray and lab services	Plan pays 100% after deductible	Plan pays 60% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100% after deductible	Plan pays 60% after deductible
Therapy Services		
	Calendar year visit limits are combined between in-network and out-of-network	
• Speech Therapy	\$25 copayment; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
• Physical, occupational therapy	\$25 copayment; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
• Chiropractic Care	\$15 copayment; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
• Respiratory therapy	Plan pays 100% after deductible; 30-visit calendar year maximum	Plan pays 60% after deductible; 30-visit calendar year maximum
• Radiation therapy, chemotherapy	Plan pays 100% after deductible	Plan pays 60% after deductible
Mental Health/Substance Abuse Services		
	No Primary Care Physician referral required. Services must be authorized by calling 1-800-292-2879	
• Inpatient (facility and physician fee)	Plan pays 100% after deductible; 30-day calendar year maximum	Not covered
• Partial Hospitalization Program (facility and physician fee)/Intensive Outpatient (facility fee only)	Plan pays 100% after deductible; 5-day/visit calendar year maximum (<i>not part of 30 days per calendar year Inpatient Mental Health benefit</i>)	Not covered
• Professional Outpatient Services	\$25 copayment; 20-visit calendar year maximum	Not covered
• Inpatient Substance Abuse Detoxification	Plan pays 100% after deductible; 6-day calendar year maximum (<i>part of the 30 days per calendar year Inpatient Mental Health benefit</i>)	Not covered
Other Services		
	Calendar year maximum is combined between in-network and out-of-network	
• Skilled nursing facility	Plan pays 100% after deductible; 30-day calendar year maximum	Plan pays 60% after deductible; 30-day calendar year maximum
• Home health care	Plan pays 100% after deductible; 120-calendar year maximum	Plan pays 60% after deductible; 120-visit calendar year maximum
• Hospice Care (<i>\$10,000 lifetime maximum</i>)	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 100% (<i>not subject to deductible</i>)
• Ambulance (<i>when medically necessary</i>)	Plan pays 100% (<i>not subject to deductible</i>)	Plan pays 100% (<i>not subject to deductible</i>)
Prescription Drugs		
To receive maximum coverage, have your prescriptions written by a network physician and filled at one of the pharmacies in our network. These include certain local independent pharmacies, as well as many national chain pharmacies: Bi-Lo, CVS, Eckerd, Ingles, Kmart, Kroger, Publix, Rite Aid, Target, Walgreens, Wal-Mart, Winn-Dixie/Save-Rite.	Unless otherwise indicated in the Certificate Booklet, each prescription has a 30-day supply limit.	
	Each mail order maintenance prescription has a 90-day supply limit.	
• Generic Formulary Drug	\$15 copayment per prescription	Plan pays 60%
• Brand Formulary Drug	\$30 copayment per prescription	Plan pays 60%
• Non- Formulary Drug	\$60 copayment per prescription	Plan pays 60%
• Mail-Order Maintenance Drug - Generic Formulary	\$30 copayment per prescription	Not Covered
• Mail-Order Maintenance Drug - Brand Formulary	\$60 copayment per prescription	Not Covered
• Mail-Order Maintenance Drug - Non-Formulary	Not Covered	Not Covered

For a full disclosure of all benefits, exclusions and limitations please refer to your Certificate Booklet.

Pre-Existing Condition Limitation and Credit for Prior Coverage

For in-network services, there is no pre-existing condition limitation. For out-of-network services, benefits are not available during a pre-existing limitation period for services for any illness, injury or condition for which medical advice or treatment was recommended by, or received from, a health care provider within six months preceding the effective date of coverage. *The pre-existing limitation period may be reduced or eliminated by the submission of a certificate of prior creditable coverage.* The pre-existing limitation period does not apply to maternity services.

Summary of Limitations and Exclusions

Your *Certificate Booklet* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and extraction of impacted teeth
- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Surgical or medical care for: artificial insemination, in-vitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood
- Smoking cessation products

See Certificate Booklet for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your *Certificate Booklet Form # F-1681.772* (the contract) for a complete explanation of covered services, limitations and exclusions.



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