



## Blue Value PPO – Small Group Plan 1503SX 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 (combined for in- and out-of-network): <i>one deductible for employee, one for spouse, one for all eligible children combined</i>		
- Individual	\$500	\$1,000
- Family	\$1,500	\$3,000
-		
Coinsurance	Plan pays 80% after deductible Member pays 20% after deductible	Plan pays 60% after deductible Member pays 40% after deductible
Lifetime Maximum	\$5,000,000	\$5,000,000
Out-of-Pocket Calendar Year Maximum*	\$2,000	\$4,000
- Individual	\$6,000	\$12,000
- Family		

\*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 maximums: deductibles, copayment amounts, non-emergency room copayment, non-covered items and coinsurance for behavioral health/substance abuse). Amounts satisfied toward the out-of-network, out-of-pocket limit will also be applied toward the in-network, out-of-pocket limit. Amounts satisfied toward the in-network, out-of-pocket will not be applied toward the out-of-network, out-of-pocket limit.

Covered Services	In-Network	Out-of-Network
<b>Office Visits: Preventive Care</b>		
• Well-child care, immunizations	\$25 Preferred Physician copayment \$25 Specialist Physician copayment	Plan pays 60% after deductible <i>(deductible waived through age 5)</i>
• Periodic health examinations, adults & dependent children under age 19, including - Annual gynecology examination - Routine mammogram - Prostate screening - Second surgical opinion	\$25 Preferred Physician copayment \$25 Specialist Physician copayment	Plan pays 60% after deductible <i>(periodic health examinations not covered)</i>
<b>Illness or Injury</b>		
• Preferred Physician office visit (including diagnostic X-rays and laboratory performed in physician's office)	\$25 Preferred Physician copayment	Plan pays 60% after deductible
• Specialist Physician office visit (including diagnostic X-rays and laboratory performed in physician's office)	\$25 Specialist Physician copayment	Plan pays 60% after deductible
• Surgery in physician's office	Plan pays 80% after deductible	Plan pays 60% after deductible
• Allergy care (office visit, testing, serum, and allergy shots)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Maternity physician services (prenatal, delivery, postpartum)	\$100 copayment <i>(first office visit only)</i>	Plan pays 60% after deductible
<b>Emergency Room Services</b>		
• Life-threatening illness, serious accidental injury	\$100 copayment <i>(waived if admitted)</i>	\$100 copayment, <i>(waived if admitted)</i>
• Non-emergency use of the emergency room	\$100 copayment; Plan pays 80% after copayment and deductible	\$100 copayment; Plan pays 60% after copayment and deductible

Covered Services	In-Network	Out-of-Network
<b>Inpatient Services</b>		
<ul style="list-style-type: none"> <li>Daily room, board and general nursing care at semi-private room rate; ICU/CCU charges; other medically necessary hospital charges such as diagnostic X-ray and lab services; newborn nursery care</li> </ul>	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> <li>Physician (surgeon, anesthesiologist, radiologist, pathologist, etc.)</li> </ul>	Plan pays 80% after deductible	Plan pays 60% after deductible
<b>Outpatient Services</b>		
<ul style="list-style-type: none"> <li>Facility/hospital charges (including diagnostic X-ray and lab services)</li> </ul>	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> <li>Physician (surgeon, anesthesiologist, radiologist, pathologist, etc)</li> </ul>	Plan pays 80% after deductible	Plan pays 60% after deductible
<b>Therapy Services</b>		
	<b>Calendar year visit limits are combined between in-network and out-of-network</b>	
- Speech therapy	Plan pays 80% after deductible; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
- Physical, occupational therapy, chiropractic care and services of athletic trainers	Plan pays 80% after deductible; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
- Respiratory therapy	Plan pays 80% after deductible; 30-visit calendar year maximum	Plan pays 60% after deductible; 30-visit calendar year maximum
- Radiation therapy and chemotherapy	Plan pays 80% after deductible	Plan pays 60% after deductible
<b>Mental Health/Substance Abuse</b>		
	<b>Calendar year visit limits are combined between in-network and out-of-network</b>	
• Inpatient (facility and physician fee)	Plan pays 80% after deductible; 30-day calendar year maximum	Plan pays 60% after deductible; 30-day calendar year maximum
• Outpatient	\$25 copayment; 20-visit calendar year maximum	Plan pays 60% after deductible; 20-visit calendar year maximum
<b>Other Services</b>		
	<b>Calendar year benefits, calendar year visits and lifetime maximums are combined between in-network and out-of-network</b>	
• Skilled nursing facility	Plan pays 80% after deductible; 30-day calendar year maximum	Plan pays 60% after deductible; 30-day calendar year maximum
• Private duty nursing (RN and LPN)	Plan pays 80% after deductible; \$2,500 benefit maximum per calendar year	Plan pays 60% after deductible; \$2,500 benefit maximum per calendar year
• Temporomandibular Joint Dysfunction (TMJ) ( <i>\$15,000 lifetime maximum</i> )	Plan pays 80% after deductible	Plan pays 60% after deductible
• Home health care	\$25 copayment per visit; 120-visit annual maximum	Plan pays 60% after deductible; 120-visit annual 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%	Plan pays 100%
<b>Prescription Drugs</b>		
Retail drug coverage is provided at one of three copayment benefit levels in accordance with the Preferred Drug List when drugs are purchased at a participating or non-participating pharmacy	Unless otherwise indicated in the Certificate Booklet, each prescription has a 30-day supply limit	
	Member must file claim form for reimbursement when using a non-participating pharmacy	
	Each mail order maintenance prescription has a 90-day supply limit	
Generic Preferred Drug	\$20 copayment	
Brand Preferred Drug	\$35 copayment	
Non-Preferred Drug	\$60 copayment	
Mail-Order Maintenance Drug ( <i>excludes non-preferred</i> )	\$60 copayment	

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**

Until a member has had "creditable coverage" for 12 consecutive months, benefits for service shall not be available 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 (excepting maternity services, for which the pre-existing condition limitation is not applicable).

### **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-1681.792* (the contract) for a complete explanation of covered services, limitations and exclusions



***The Power of Blue<sup>SM</sup>***

3350 Peachtree Road, NE • Atlanta, Georgia 30326 • 1-800-441-2273  
Independent Licensee of the Blue Cross Blue Shield Association  
® Registered Mark of the Blue Cross Blue Shield Association

0009935 10/05