



Blue Value Plan HMO – Small Group Plan 3001SX Benefit Summary

In addition to copayments, members are responsible for coinsurance 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*.

Deductibles, Maximums, etc.

Calendar Year Deductible: *one deductible for employee, one for spouse, one for all eligible children combined*

- Individual
- Family

Coinsurance

Lifetime Maximum

Out-of-Pocket Calendar Year Maximum*

- Individual
- 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 copayments, non-covered items and coinsurance for behavioral health/substance abuse.

In-Network Benefit Level

No Coverage for Out-of-Network

\$500
\$1,500

Plan pays 100%

Unlimited

None
None

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

Covered Services	In-Network Benefit Level
Outpatient Services	
• Surgery facility/hospital charges	\$100 copayment; plan pays 100% after copayment
• Diagnostic X-ray and lab services	Plan pays 100% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100% after deductible
Therapy Services	
- Speech Therapy	\$25 copayment; 20-visit calendar year maximum
- Physical, Occupational Therapy	\$25 copayment; 20-visit calendar year maximum
- Chiropractic Care	\$15 copayment; 20-visit calendar year maximum
- Respiratory Therapy	Plan pays 100% after deductible; 30-visit calendar year maximum
- Radiation Therapy, Chemotherapy	Plan pays 100% after deductible
Behavioral Health/Substance Abuse Services	
• Inpatient (facility and physician fee)	Plan pays 100% after deductible; 30-day calendar year maximum
• Outpatient	\$25 copayment; 20-visit calendar year maximum
• Inpatient Substance Abuse Detoxification	Plan pays 100% after deductible; 6-day calendar year maximum (<i>part of 30 days calendar year Inpatient Behavioral Health benefit</i>)
Other Services	
• Skilled Nursing Facility	Plan pays 100% after deductible; 30-day calendar year maximum
• Home Health Care	Plan pays 100% after deductible; 120-visit annual maximum
• Hospice Care (<i>\$10,000 lifetime maximum</i>)	Plan pays 100% (<i>not subject to deductible</i>)
• Ambulance	Plan pays 100% (<i>when medically necessary</i>)
Prescription Drugs	
Participating pharmacies include: Bi-Lo, CVS, Eckerd, Kmart, Kroger, Publix, SaveRite, Target, Walgreens, WalMart, Winn-Dixie and many independent pharmacies	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 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 per prescription

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-1681.782* (the contract) for a complete explanation of covered services, limitations and exclusions.



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