



Blue Value PPO – Small Group Plan 1502SX 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	\$1,500	\$3,000
- Family	\$4,500	\$9,000
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*		
- Individual	\$1,000	\$2,000
- Family	\$3,000	\$6,000

*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 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
Office Visits: Preventive Care		
• Well-child care, immunizations	\$40 Preferred Physician copayment \$40 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 - Mammogram - Prostate screening - Second surgical opinion	\$40 Preferred Physician copayment \$40 Specialist Physician copayment	Plan pays 60% after deductible <i>(periodic health examinations not covered)</i>
Illness or Injury		
• Preferred Physician office visit (including diagnostic X-rays and laboratory performed in physician's office)	\$40 Preferred Physician copayment	Plan pays 60% after deductible
• Specialist Physician office visit (including diagnostic X-rays and laboratory performed in physician's office)	\$40 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 (testing, serum, and allergy shots)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Maternity physician service (prenatal, delivery, postpartum)	\$100 copayment <i>(first office visit only)</i>	Plan pays 60% after deductible
Emergency Room Services		
• 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
Inpatient Services		
<ul style="list-style-type: none"> 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 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> Physician (surgeon, anesthesiologist, radiologist, pathologist, etc.) 	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Services		
<ul style="list-style-type: none"> Facility/hospital charges (including diagnostic X-ray and lab services) 	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> Physician (surgeon, anesthesiologist, radiologist, pathologist, etc) 	Plan pays 80% after deductible	Plan pays 60% after deductible
Therapy Services		
	Calendar year visit limits are combined between in-network and out-of-network	
- 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
Behavioral Health/Substance Abuse		
	Calendar year visit limits are combined between in-network and out-of-network	
<ul style="list-style-type: none"> Inpatient (facility and physician fee) 	Plan pays 80%; 30-day calendar year maximum	Plan pays 60%; 30-day calendar year maximum
<ul style="list-style-type: none"> Outpatient 	\$40 copayment; 20-visit calendar year maximum	Plan pays 60%; 20-visit calendar year maximum
Other Services		
	Calendar year benefits, calendar year visits and lifetime maximums are combined between in-network and out-of-network	
<ul style="list-style-type: none"> Skilled nursing facility 	Plan pays 80% after deductible; 30-day calendar year maximum	Plan pays 60% after deductible; 30-day calendar year maximum
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Temporomandibular Joint Dysfunction (TMJ) (<i>\$15,000 lifetime maximum</i>) 	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> Home health care 	\$40 copayment per visit; 120-visit calendar year maximum	Plan pays 60% after deductible; 120-visit calendar year maximum
<ul style="list-style-type: none"> 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>)
<ul style="list-style-type: none"> Ambulance (<i>when medically necessary</i>) 	Plan pays 100%	Plan pays 100%
Prescription Drugs		
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	<p>Unless otherwise indicated in the Certificate Booklet, each prescription has a 30-day supply limit</p> <p>Member must file claim form for reimbursement when using a non-participating pharmacy</p> <p>Each mail order maintenance prescription has a 90-day supply limit</p>	
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 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-1681.792* (the contract) for a complete explanation of covered services, limitations and exclusions



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