



Blue Value HMO – Large Group (51+ Employees) Plan 6803SX 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 mental health/substance abuse.

In-Network Benefit Level

No Coverage for Out-of-Network

\$5,000
\$15,000
Plan pays 70% after deductible
Member pays 30% after deductible
Unlimited

Covered Services

In-Network Benefit Level

Office Visits: Preventive Care

• Well-child care, immunizations	\$40 copayment
• Periodic health examinations	\$40 copayment
• Annual gynecology examination (No PCP referral required)	\$40 copayment
• Prostate screening	\$40 copayment

Illness or Injury

• Primary Care Physician (PCP) office visit (includes lab, radiology and office surgery)	\$40 copayment
• Primary care physician after hours office visit	\$45 copayment
• Specialty care physician office visit (PCP referral required)	\$40 copayment
• Second surgical opinion (PCP referral required)	\$40 copayment
• Maternity physician services (prenatal, delivery, postpartum)	\$1,000 copayment (<i>first office visit only</i>)
• Allergy care (office visit, testing, serum and allergy shots)	\$40 copayment
• Vision care services provided by network ophthalmologist or optometrist for the treatment of acute conditions (No PCP referral required)	\$40 copayment
• Services provided by a network dermatologist (No PCP referral required)	\$40 copayment

Emergency Room Services

• Life-threatening illness, serious accidental injury or with a PCP referral	\$150 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	\$1,000 copayment; plan pays 70% after copayment
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 70% after deductible

Covered Services	In-Network Benefit Level
Outpatient Services	
• Surgery facility/hospital charges	Plan pays 70% after deductible
• Diagnostic x-ray and lab services	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 70% after deductible
Therapy Services	
• Speech Therapy	\$40 copayment; 20-visit calendar year maximum
• Physical, Occupational Therapy	\$40 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
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)	\$1,000 copayment; plan pays 70% after copayment; 30-day calendar year maximum
• Partial Hospitalization Program (facility and physician fee) / Intensive Outpatient (facility fee only)	Plan pays 70% after deductible; 5-day/visit calendar year maximum (<i>not part of 30 days per calendar year Inpatient Mental Health benefit</i>)
• Professional Outpatient Services	\$40 copayment; 20-visit calendar year maximum
• Inpatient Substance Abuse Detoxification	\$1,000 copayment; plan pays 70% after copayment; 6-day calendar year maximum (<i>part of the 30 days per calendar year Inpatient Mental 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 calendar year maximum
• Hospice Care (<i>\$10,000 lifetime maximum</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>)
Prescription Drugs	
To receive 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.
Calendar Year Deductible, per member	\$250
• Generic Formulary Drug	\$15 copayment per prescription
• Brand Formulary Drug	\$30 copayment per prescription
• Non-Formulary Drug	Not Covered
• Mail-Order Maintenance Drug - Generic Formulary	\$30 copayment per prescription
• Mail-Order Maintenance Drug - Brand Formulary	\$60 copayment per prescription
• Mail-Order Maintenance Drug - Non-Formulary	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

Under BlueChoice Healthcare Plan, there are no pre-existing condition limitations. All in-network, covered services are eligible for benefits from your first day of coverage.

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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