

# Individuals & Families

## Blue Value PPO Plan 2,000

### Lifetime Maximum - *In- and Out-of-Network Combined*

|                |             |
|----------------|-------------|
| In-Network     | \$5,000,000 |
| Out-of-Network | \$5,000,000 |

### Calendar Year Deductible

|                |         |
|----------------|---------|
| In-Network     | \$2,000 |
| Out-of-Network | \$4,000 |

### Coinsurance

|                |               |
|----------------|---------------|
| In-Network     | Plan pays 70% |
| Out-of-Network | Plan pays 60% |

### Calendar Year Out-of-Pocket Maximum

|                |                          |
|----------------|--------------------------|
| In-Network     | \$2,000                  |
| Out-of-Network | No Out-of-Pocket Maximum |

### Physician Office Visit

|                |  |
|----------------|--|
| In-Network     | \$40 copayment for first 6 visits, not subject to calendar year deductible; after 6 visits Plan pays 70% |
| Out-of-Network | Plan pays 60%  |

### Preventive Care for Children Through Age 5 *Not Subject to Calendar Year Deductible*

|                |               |
|----------------|---------------|
| In-Network     | Plan pays 70% |
| Out-of-Network | Plan pays 60% |

### Preventive Care for Adults\* *Not Subject to Calendar Year Deductible*

|                |               |
|----------------|---------------|
| In-Network     | Plan pays 70% |
| Out-of-Network | Plan pays 60% |

**\*\$250 benefit maximum per year in addition to state mandated coverage**

**Lab/X-ray, Surgery, Radiation, Anesthesia**

|                |               |
|----------------|---------------|
| In-Network     | Plan pays 70% |
| Out-of-Network | Plan pays 60% |

**Hospital Inpatient Services**

|                |               |
|----------------|---------------|
| In-Network     | Plan pays 70% |
| Out-of-Network | Plan pays 60% |

**Hospital-Based Physicians**

|                |               |
|----------------|---------------|
| In-Network     | Plan pays 70% |
| Out-of-Network | Plan pays 60% |

**Maternity\* - Family Contracts Only**

|                |               |
|----------------|---------------|
| In-Network     | Plan pays 70% |
| Out-of-Network | Plan pays 60% |

**\*No maternity benefits are payable for the first 12 (twelve) months of coverage**

**Outpatient Facility/Ambulatory Surgery Center**

|                |               |
|----------------|---------------|
| In-Network     | Plan pays 70% |
| Out-of-Network | Plan pays 60% |

**Physical/Occupational Therapy, Chiropractic Services**

|                |               |   |
|----------------|---------------|---|
| In-Network     | Plan pays 70% | 30 visits per year, combined specialties* |
| Out-of-Network | Plan pays 60% | 30 visits per year, combined specialties* |

\*In- and Out-of-Network Visits Combined

**Behavioral Health/Substance Abuse - Inpatient Only**

|                |  |
|----------------|--|
| In-Network     | \$100 per day; 30 day maximum; \$3,000 per year; \$10,000 lifetime maximum |
| Out-of-Network | \$100 per day; 30 day maximum; \$3,000 per year; \$10,000 lifetime maximum |

## Emergency Room Services

### Life threatening medical emergency or serious accidental injury

*Not Subject to Calendar Year Deductible*

|                |                                 |
|----------------|---------------------------------|
| In-Network     | \$150 copay, waived if admitted |
| Out-of-Network | \$150 copay, waived if admitted |

### Non-accidental injury or non-medical emergency

|                |                            |
|----------------|----------------------------|
| In-Network     | \$150 copay, Plan pays 70% |
| Out-of-Network | \$150 copay, Plan pays 60% |

### Prescription Drugs \$200 Calendar Year Drug Deductible per Member

|                   |                |
|-------------------|----------------|
| Generic Formulary | \$15 copayment |
| Brand Formulary   | \$30 copayment |
| Non-Formulary     | \$45 copayment |

**Please Note: Unless otherwise stated, all benefits are subject to the deductible.**

**Waiting period for pre-existing conditions is 12 (twelve) months from the contract effective date.**

*This is a brief summary of benefits and is not intended to be a full disclosure of benefits. To learn more about this plan, please contact your agent, or Blue Cross Blue Shield of Georgia at 1-800-718-8831.*

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