Individuals & Families

Blue Value PPO Plan 3,000

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

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

Calendar Year Deductible

In-Network	$3,000
Out-of-Network	$6,000

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***

	Facility	Professional
In-Network	$3,000 Copayment; Plan Pays 100% after copayment	Plan pays 100%, not subject to calendar year deductible
Out-of-Network	$3,000 Copayment; Plan Pays 70% after copayment	Plan pays 70%

***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 $300 Calendar Year Drug Deductible per Member

Generic Formulary	$15 copayment (*Not subject to Drug Deductible*)
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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