

# Individuals & Families

## Blue Value Select PPO Plan 500

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

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

### Calendar Year Deductible

In-Network	\$500
Out-of-Network	\$1,000

### Coinsurance

In-Network	Plan pays 80%
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	\$30 copayment, not subject to calendar year deductible
Out-of-Network	Plan pays 60%

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

In-Network	\$30 copayment
Out-of-Network	Plan pays 60%

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

In-Network	\$30 copayment
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 80%
Out-of-Network	Plan pays 60%

**Hospital Inpatient Services**

In-Network	Plan pays 80%
Out-of-Network	Plan pays 60%

**Hospital-Based Physicians**

In-Network	Plan pays 80%
Out-of-Network	Plan pays 60%

**Maternity\* - Family Contracts Only**

In-Network	Plan pays 80%
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 80%
Out-of-Network	Plan pays 60%

**Physical/Occupational Therapy, Chiropractic Services**

In-Network	Plan pays 80%	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 80%
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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