Company	BlueCross BlueShield of Georgia	
Plan Name	Premier Plus PPO	
Apply	Apply	
Estimated Monthly Premium	**Varies By Deductible**	
Plan Type	PPO	
Networks	**See provider details**	
	Network	Non-Network
Copay	$35 PCP / $50 SPC	N/A
Deductible	**750, 1500, 2500, 3500, 5000, 7500, 10,000 (Double for Families)**	
Coinsurance	20%	40%
Coinsurance Limit	**see brochure**	
Out-of-Pocket Maximum	Individual: $3,250, Family: $6,500 (Deductible included in OOP) (copayments not included in OOP max)	Individual: $8,250, Family: $16,500 (Deductible included in OOP) (copayments not included in OOP max)
Lifetime Maximum	Unlimited	
Office Visit	Doctors' Office Visits: $35 PCP / $50 SPC	30% after deductible
Prescription Drugs	Retail (34-day supply) - Tier 1: $15 copay; Tier 2: $30 copay; Tier 3: $60 copay; Tier 4: 25% coinsurance ($2,500 OOP maximum per member per year); Mail Order (90-day supply) - Tier 1: $30 copay; Tier 2: $75 copay; Tier 3: $150 copay; Tier 4: 25% coinsurance ($2,500 OOP maximum per member per year); If a brand drug is chosen when generic is available, member pays the applicable copay PLUS the difference between the brand and generic	
Emergency Room	Medical Emergency or Accident:$250 copay (Copay waived if admitted, then subject to deductible and coinsurance.); Ambulance Service(When Medically Necessary): Member pays 20% after deductible	Medical Emergency or Accident: $250 copay (Copay waived if admitted, then subject to deductible and coinsurance.); Ambulance Service(When Medically Necessary): Member pays 20% after deductible
Adult Preventive Care	Preventive Services (labs, immunizations, etc.), Age 6 and over: Member Pays 0% Deductible Waived	Preventive Services (labs, immunizations, etc.), Age 6 and over: Member Pays 30% after deductible
Child Preventive Care	Preventive Services (labs, immunizations, etc.), Children thru age 5: Member Pays 0% Deductible Waived	Preventive Services (labs, immunizations, etc.), Children thru age 5: Member Pays 30% after deductible
Lab/X-ray	Member pays 20% after deductible	Member pays 40% after deductible
Maternity	Not covered (Optional Benefit for deductibles $2500 and higher)	
Physical Therapy	Member pays 20% after deductible (20 visits per member, per year, combined specialties, in and out of network combined)	Member pays 40% after deductible (20 visits per member, per year, combined specialties, in and out of network combined)
Skilled Nursing	**see brochure**	
Home Health Care	Member pays 20% after deductible (100 visits per calendar year, in and out of network combined)	Member pays 40% after deductible (100 visits per calendar year, in and out of network combined)
Mental Health	Inpatient - Member pays 20% after deductible (30 days per member, per calendar year, in and out of network combined); Outpatient - $35 PCP/ $50 SPC (no deductible) for Office Visit; Other than Office Visit, Member Pays 20% after deductible (48 visits per member, per calendar year, in and out of network combined)	Inpatient - Member pays 40% after deductible (30 days per member, per calendar year, in and out of network combined); Outpatient - Member pays 40% after deductible (48 visits per member, per calendar year, in and out of network combined)
Hospital Care	Member pays 20% after deductible	Member pays 40% after deductible
Included Benefits	**see brochure**	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	**see brochure**	
Note	**see brochure**	
Product Brochure	**Brochure**	
Optional Riders included in the quote		
Optional Riders not included in the quote	❑ Term Life $25,000 : $4.65 ❑ Term Life $75,000 : $11.25 ❑ Term Life $15,000 : $2.80 ❑ Dental : $27.00 ❑ Term Life $50,000 : $9.30 ❑ Term Life $100,000 : $13.00	

General Disclaimers

The quotes shown above are estimates only, and are subject to change based on the proposed insured's medical history, the underwriting practices of the health plan, the selection of the appropriate Provider Network, the optional benefits selected, occupation (where allowed by state), if any, and other relevant factors. The insurance company reserves the right to change the terms of a policy upon proper notification.

The quotes shown above are for the requested effective date ONLY. If the actual effective date of coverage is different from the requested effective date, the actual cost may differ from the quote above due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier selected may not guarantee its rates for any period of time.

Applicants should not cancel any in-force health coverage until written formal approval from the insurance company selected is received.

This is not a complete solicitation of health insurance coverage. Please refer to sales brochure and applicable inserts for further information. Sales brochures and applicable inserts may be downloaded or can be obtained by calling our contact number near the top of this page.

The benefits shown in the details summary are not guaranteed. Please refer to the sales brochure and applicable inserts for further information.

Carrier Specific Disclaimers

Blue Cross Blue Shield of Georgia

Blue Cross Blue Shield of Georgia is an Independent Licensee of the Blue Cross Blue Shield Association.

Due to ongoing uncertainty, Anthem has made the decision to suspend the sale of child-only policies and policies where the primary subscriber is under 19 years of age, for effective dates of 9/23 or later.