Company	BlueCross BlueShield of Georgia	
Plan Name	Premier Plus POS	
Apply	Apply	
Estimated Monthly Premium	Varies By Deductible	
Plan Type	POS	
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	Varies by deductible. Please see brochure.	
Coinsurance Limit	see brochure	
Out-of-Pocket Maximum	Varies by deductible. Please see brochure.	
Lifetime Maximum	Unlimited	
Office Visit	Physician Office Visits (not Preventive Visits): $35 PCP / $50 SPC	Physician Office Visits (not Preventive Visits): Member pays 50%
Prescription Drugs	Retail (up to 34-days 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-days 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	Varies by deductible. Please see brochure.	Medical Emergency or Accident: $250 copay (Copay waived if admitted) Non-Medical Emergency or Non-Serious Accidental Injury: Member pays 50%
Adult Preventive Care		Preventive Care (Age 6 & older): Member pays 50%
Child Preventive Care		Preventive Care (Children through age 5): Member pays 50%
Lab/X-ray		Member pays 50%
Maternity	Not covered (Optional Coverage Available)	
Physical Therapy	Varies by deductible. Please see brochure.	Member pays 50% (20 visits per member, per year, combined specialties, in and out-of-combined)
Skilled Nursing	see brochure	
Home Health Care	Varies by deductible. Please see brochure.	Member pays 50% (100 visits per calendar year, in and out-of-network combined)
Mental Health		Mental Health Care/Substance Abuse - Inpatient: Member pays 50% (30-days per member, per calendar year, in and out-of-network combined) Outpatient: Member pays 50% (48 visits per member, per calendar year, in and out-of-network combined)
Hospital Care	Member pays 0%	Member pays 50%
Included Benefits	see brochure	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	see brochure	
Note	To view your Summary of Benefits and Coverage please visit www.healthcare.gov.	
Product Brochure	Brochure	
Summary of Benefits and Coverage		
Optional Riders included in the quote		
Optional Riders not included in the quote	❑ Dental : $27.00 ❑ Term Life $50,000 : $10.80 ❑ Term Life $25,000 : $5.40 ❑ Term Life $15,000 : $3.25 ❑ Term Life $100,000 : $16.00 ❑ Term Life $75,000 : $13.50	

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.

The Short Term quotes noted above are for 30 days of coverage, which may be more or less than a full month. Coverage is available in daily increments only between 30 and 180 days.

To view your Summary of Benefits and Coverage please visit www.healthcare.gov (Not applicable for Short Term plans)