


Prepared For:	30
Prepared By:	Mk
Phone Number:	80
Date Prepared:	4/2
Zip Code:	30
Effective Date:	5/1
Applicant:	Mk




Company		
Plan Name	SmartSense Plus POS	
Apply	<a href="#">Apply</a>	
Estimated Monthly Premium	\$69.68	
Plan Type	POS	
Networks	<a href="#">See provider details</a>	
	Network	Non-Network
Copay	\$30	N/A
Deductible	Individual: \$10,000, Family: \$20,000 (All benefits covered after deductible unless noted)	
Coinsurance	Member pays 30%	Member pays 50%
Coinsurance Limit	<a href="#">see brochure</a>	
Out-of-Pocket Maximum	Individual: \$13,000, Family: \$26,000	Individual: \$17,500, Family: \$35,000
Lifetime Maximum	Unlimited	
Office Visit	Physician Office Visit (Non-Preventive): \$30 copay for first 3 visits per member per year with deductible waived; after 3 visits, once deductible is met then 30% coinsurance	Physician Office Visit (Non-Preventive): Member pays 50%
Prescription Drugs	Retail (34-day supply) - Generally Generic (May include single source brand drugs or multi-source brand drugs - not subject to deductible): \$15 copay or 40% coinsurance, whichever is greater Non-Preferred Brand and Specialty Drugs: Not covered - discount available Mail Order (90-day supply): Same benefit as retail above	Same benefit and limits as in-network except the member is responsible for filing the claim and for the difference between the pharmacy charge and our allowable charge.
Emergency Room	Medical Emergency or Accident (when deemed an emergency as defined by Anthem): Member pays \$500 copay (waived if admitted) Non-Medical Emergency or Non-Serious Accidental Injury: Member pays 30%	Medical Emergency or Accident (when deemed an emergency as defined by Anthem): Member pays \$500 copay (waived if admitted) Non-Medical Emergency or Non-Serious Accidental Injury: Member pays 50%
Adult Preventive Care	Member pays 0% (Deductible waived)	Member pays 100%
Child Preventive Care	Member pays 0% (Deductible waived)	Member pays 50% (Deductible waived)
Lab/X-ray	Member pays 30%	Member pays 50%
Maternity	Not covered	
Physical Therapy	Member pays 30% (30 visits per person, per calendar year, combined specialties combined in and out-of-network)	Member pays 50% (30 visits per person, per calendar year, combined specialties combined in and out-of-network)
Skilled Nursing	<a href="#">see brochure</a>	
Home Health Care	Member pays 30% (100 visits)	Member pays 50% (100 visits)
Mental Health	Mental Health Care/Substance Abuse - Inpatient: Member pays 30% (30-day limit) Outpatient: Member pays 30% (48 visit limit)	Mental Health Care/Substance Abuse - Inpatient: Member pays 50% (30-day limit) Outpatient: Member pays 50% (48 visit limit)
Hospital Care	Member pays 30%	Member pays 50%
Included Benefits	<a href="#">see brochure</a>	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	<a href="#">see brochure</a>	
Note	To view your Summary of Benefits and Coverage please visit <a href="http://www.healthcare.gov">www.healthcare.gov</a> .	
Product Brochure	<a href="#">Brochure</a>	
Summary of Benefits and Coverage		
Optional Riders included in the quote		
Optional Riders not included in the quote	<input type="checkbox"/> Dental : \$27.00 <input type="checkbox"/> Term Life \$50,000 : \$10.80 <input type="checkbox"/> Term Life \$25,000 : \$5.40 <input type="checkbox"/> Term Life \$15,000 : \$3.25 <input type="checkbox"/> Term Life \$100,000 : \$16.00 <input type="checkbox"/> 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](http://www.healthcare.gov) (Not applicable for Short Term plans)

Norvax form #DS-1