

Prepared For:	8020
Prepared By:	Medi
Phone Number:	800.5
Date Prepared:	3/16/
Zip Code:	8020
Effective Date:	4/1/2
Applicant:	Male




Anthem BCBS CO: Please make sure you have completed the Prescreening questionnaire for individual health benefit process before you proceed with this application. If you need to locate the questionnaire, please [click here](#).

Company		
Plan Name	ClearProtection	
Apply	<a href="#">Apply</a>	
Estimated Monthly Premium	\$139.00	
Plan Type	PPO	
Networks	<a href="#">See provider details</a>	
	Network	Non-Network
Copay	\$40	N/A
Deductible	Individual: \$1,000, Family: \$2,000	
Coinsurance	30%	50%
Coinsurance Limit	<a href="#">see brochure</a>	
Out-of-Pocket Maximum	Individual: \$3,500, Family: \$7,000 (plus deductible)	
Lifetime Maximum	Unlimited	
Office Visit	First 2 Office Visits (per member): \$40 copay, deductible waived Additional Office Visits: 100% of negotiated fee; then 0% coinsurance after out-of-pocket is met	100% coinsurance; then 0% coinsurance after out-of-pocket maximum is met
Prescription Drugs	Retail Drugs (and Mail Order Drugs when available) - Tier 1 (Generic drugs): \$15 copay \$7,500 annual Prescription Drug deductible per member applies before the following - Tier 2 (Formulary Brand name drugs): \$40 copay Tier 3 (Non-Formulary Brand name drugs): \$60 copay Specialty: 25% coinsurance up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to \$7,500 annual deductible	Retail Drugs (and Mail Order Drugs when available): Not Covered
Emergency Room	30% of negotiated fee; \$100 ER copay, waived if admitted	
Adult Preventive Care	0% coinsurance, not subject to deductible (Includes all nationally recommended, preventive services including immunizations, PSA screenings, Pap tests, mammograms and more)	Nationally Recommended Preventive Services: \$40 copay (Includes all nationally recommended preventive services including immunizations, PSA screenings, Pap tests, mammograms and more) Non-Mandated Preventive Services: Not Covered
Child Preventive Care	0% coinsurance, not subject to deductible (Includes all nationally recommended, preventive services including well-child care, immunizations, and more)	Nationally Recommended Preventive Services: \$40 copay (Includes all nationally recommended, preventive services including well-child care, immunizations, and more) Non-Mandated Preventive Services: Not Covered
Lab/X-ray	Inpatient: 30% coinsurance Outpatient: 100% of negotiated fee; then 0% coinsurance after out-of-pocket maximum is met	Inpatient: 50% coinsurance Outpatient: 100% of negotiated fee; then 0% coinsurance after out-of-pocket maximum is met
Maternity	Inpatient: 30% coinsurance Outpatient: 100% of negotiated fee; then 0% coinsurance after out-of-pocket maximum is met	Inpatient: 50% coinsurance Outpatient: 100% of negotiated fee; then 0% coinsurance after out-of-pocket maximum is met
Physical Therapy	Benefits Included, see brochure for more coverage details	
Skilled Nursing	Benefits Included, see brochure for more coverage details	
Home Health Care	Benefits Included, see brochure for more coverage details	
Mental Health	Not Covered	
Hospital Care	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.) - Inpatient: 30% coinsurance Outpatient: 100% of negotiated fee; then 0% coinsurance after out-of-pocket maximum is met Inpatient Services (overnight hospital/facility stays): 30% coinsurance Outpatient Services (without overnight hospital/facility stays) - Surgery: 30% coinsurance Other Services: 100% of negotiated fee; then 0% coinsurance after out-of-pocket maximum is met	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.) - Inpatient: 50% coinsurance Outpatient: 100% of negotiated fee; then 0% coinsurance after out-of-pocket maximum is met Inpatient Services (overnight hospital/facility stays): 50% coinsurance after deductible, then 0% coinsurance after out-of-pocket maximum is met Outpatient Services (without overnight hospital/facility stays): 100% coinsurance after deductible, then 0% coinsurance after out-of-pocket maximum is met
Included Benefits	<a href="#">see brochure</a>	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	<a href="#">see brochure</a>	

<b>Note</b>	Deductible - For Inpatient/Surgical and Emergency Room Services - Individual: \$1,000, Family: \$2,000 For Outpatient/Professional and Diagnostic Services - Individual: \$4,500, Family: \$9,000 Coinsurance - For Inpatient/Surgical and Emergency Room Services: 30% For Outpatient/Professional and Diagnostic Services: 0% Out-of-Pocket Maximum - For Inpatient/Surgical and Emergency Room Services - Individual: \$3,500, Family: \$7,000 (plus deductible) For Outpatient/Professional and Diagnostic Services - Individual: \$0, Family: \$0 (plus deductible) Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.
<b>Product Brochure</b>	<a href="#">Brochure</a>
<b>Optional Riders included in the quote</b>	
<b>Optional Riders not included in the quote</b>	

**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**

**Anthem**

Please note that any premium rates quoted may be subject to changed based on actual effective date, responses to applications questions, age of applicant(s) on actual effective date, geographic location, risk tier adjustments, scheduled rate adjustments and/or rate guarantee periods or anniversary month, if applicable.

Premium quotes do not include administrative fees that may apply upon approval of your application and enrollment.

The rates shown above do not include any applicable adjustments related to reinstatement, electronic premium payments, insufficient funds, the CoverColorado \$3.76 assessment, etc.

Norvax form #DS-1
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