Company	Anthem.	
Plan Name	Premier	
Apply	Apply	
Estimated Monthly Premium	**Varies By Deductible**	
Plan Type	PPO	
Networks	**See provider details**	
	Network	Non-Network
Copay	$30	N/A
Deductible	**1000, 1500, 2500, 3500, 5000, 6000**	
Coinsurance	25%	50%
Coinsurance Limit	**see brochure**	
Out-of-Pocket Maximum	Individual: $4,500, Family: $9,000 (plus deductible)	Individual: $7,500, Family: $15,000 (plus deductible)
Lifetime Maximum	Unlimited	
Office Visit	Office Visit $30 copay for primary care physician; $50 copay for specialist (deductible waived for both)	50% coinsurance
Prescription Drugs	Prescription Drugs (and Mail Order Drugs when available) - Tier 1 (Generic drugs): $15 copay $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 $500 annual deductible	Prescription Drugs (and Mail Order Drugs when available): Not Covered
Emergency Room	25% coinsurance	
Adult Preventive Care	0% coinsurance, not subject to deductible (Includes all nationally recommended preventive services including immunizations, PSA screenings, Pap tests, mammograms and more)	Routine mammogram, Pap, PSA and Colorectal screenings: $30 copay, deductible waived All other covered services: 50% coinsurance
Child Preventive Care	0% coinsurance, not subject to deductible (Includes all nationally recommended preventive services including well-child care, immunizations, and more)	Immunizations (children under age 13) covered at no cost to member, deductible waived
Lab/X-ray	25% coinsurance	50% coinsurance
Maternity	25% coinsurance	50% coinsurance
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	Benefits Included, see brochure for more coverage details	
Hospital Care	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 25% coinsurance Inpatient Services (overnight hospital/facility stays): 25% coinsurance Outpatient Services (without overnight hospital/facility stays): 25% coinsurance	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 50% coinsurance Inpatient Services (overnight hospital/facility stays): 50% coinsurance Outpatient Services (without overnight hospital/facility stays): 50% coinsurance
Included Benefits	Eye Exam: $20	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	**see brochure**	
Note	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	
Product Brochure	**Brochure**	
Optional Riders included in the quote		
Optional Riders not included in the quote		

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.