mediCOVERAGE™
health insurance starts here

Company	Anthem. BlueCross BlueShield	
Plan Name	Premier	
Apply	Apply	
Estimated Monthly Premium	**Varies By Deductible**	
Plan Type	PPO	
Networks	**See provider details**	
	Network	Non-Network
Copay	$30	
Deductible	**500, 1500, 2500, 3500, 5000, 7500, 10,000 (Double for Families)**	
Coinsurance	20%	30%
Coinsurance Limit	**see brochure**	
Out-of-Pocket Maximum	Individual: $2,500, Family: $5,000	Individual: $8,000, Family: $16,000
Lifetime Maximum	Unlimited	
Office Visit	Office Visits: Primary Care Physician: $30 copay deductible waived; Specialist: $40 copay deductible waived	Office Visits: Primary Care Physician: 30% after deductible; Specialist: 30% after deductible
Prescription Drugs	Retail Drugs and Mail Order Drugs when available; Generic and Brand Name Drugs (deductible waived): $15 copay or 40% coinsurance, whichever is greater; Specialty Drugs: 40% coinsurance deductible waived; Annual Prescription Drug Maximum per Person (In & Out of Network Combined; Retail & Mail Order also combined) - Unlimited	Retail Drugs and Mail Order Drugs when available; Generic and Brand Name Drugs (deductible waived): $15 copay or 40% coinsurance, whichever is greater; Specialty Drugs: 40% coinsurance deductible waived; Member is responsible for filing the claim and for the difference between the pharmacy charge and allowable charge, plus applicable copay and coinsurance; Annual Prescription Drug Maximum per Person (In & Out of Network Combined; Retail & Mail Order also combined) - Unlimited
Emergency Room	Emergency Room (Medical Emergency or Accident): 20% after deductible; Emergency Room (Non-Medical Emergency or Non-Serious Accidental Injury): 20% after deductible; Ambulance Services: 20% after deductible	Emergency Room (Medical Emergency or Accident): 20% after deductible; Emergency Room (Non-Medical Emergency or Non-Serious Accidental Injury):30% after deductible; Ambulance Services: 30% after deductible
Adult Preventive Care	Member pays 0% (Deductible waived); Routine Mammmogram Screenings - 1 per year per member for ages 35 & older (in and out of network combined); Routine Office Visits (office visit only) - Unlimited visits; Routine Pap Test - 1 per year per member (in and out of network combined)	Member pays 30% (Deductible waived); Routine Mammmogram Screenings - 1 per year per member for ages 35 & older (in and out of network combined); Routine Office Visits (office visit only) - Unlimited visits; Routine Pap Test - 1 per year per member (in and out of network combined)
Child Preventive Care	Preventive Care & Immunizations for Children (from birth through 6 years of age) - Member pays 0% (Deductible & copays waived)	
Lab/X-ray	**see brochure**	
Maternity	Complications of Pregnancy only	
Physical Therapy	Outpatient Physical/Occupational Therapy: Member pays 20% after deductible; Limitations (in and out of network combined) - 20 visits per member, per calendar year	Outpatient Physical/Occupational Therapy: Member pays 30% after deductible; Limitations (in and out of network combined) - 20 visits per member, per calendar year
Skilled Nursing	Skilled Nursing: 20% after deductible (100 day limit per year per person, in and out-of-network combined)	Skilled Nursing: 30% after deductible (100 day limit per year per person, in and out-of-network combined)
Home Health Care	Home Health Care: 20% after deductible (90 visit limit per year per person); Hospice: 20% after deductible	Home Health Care: 30% after deductible (90 visit limit per year per person); Hospice: 30% after deductible
Mental Health	Mental Health and Substance Abuse - Inpatient: 20% after deductible (25 day limit per year per person; 10 Inpatient days can converted to 15 partial days); Outpatient (20 visit limit per year, per person): Inside Physician Office: Primary Care Physician: $30 copay (Visits 1-5); Specialist: $40 copay (Visits 1-5); 50% deductible waived (Visits 6-20); Outside Physician Office: Visits 1-5: 20% after deductible; Visits 6-20: 50% after deductible	Mental Health and Substance Abuse - Inpatient: 30% after deductible (25 day limit per year per person; 10 Inpatient days can converted to 15 partial days); Outpatient (20 visit limit per person, per year): Visits 1-5: 30% after deductible; Visits 6-20: 50% after deductible
Hospital Care	Inpatient Services (overnight hospital/facility stays): 20% after deductible; Out patient Services (overnight hospital/facility stays): 20% after deductible	Inpatient Services (overnight hospital/facility stays): 30% after deductible; Out patient Services (overnight hospital/facility stays): 30% 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	❑ Dental : $23.00 ❑ Supplemental Accident : $12.00	

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

Anthem Blue Cross and Blue Shield of Virginia

This quote is good through the current month or until your age changes, whichever occurs first. It is based on information you provided and is only intended to give you a basic idea of what your premium will be. Your actual premium will be based on your answers to questions on your application, and on any information provided by your physician. Our service area is Virginia, excluding the city of Fairfax, the town of Vienna, and the area east of State Route 123. Individual KeyCare Preferred, Individual Essential KeyCare, Individual KeyCare HSA, Individual KeyCare HealthSmart, Individual KeyCare with Enhanced Drug Benefit, and Individual KeyCare Flexible Choice are only offered in certain parts of Virginia. Contact your Anthem Sales Representative for more details. 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. This rate quote is only part of the complete product information available to you on this site. For more information about benefits, limitations, and exclusions, please refer to the brochures provided on this site. You'll find this important information in the Details section beside the product name of your choice. Form #s: 916125 (11/06), 916127 (01/07), PVA2417 (11/06), 900879 Rev. 5/07, 916126 (01/07), HSA-0105, STO-0106, TO-0106, DOBROC (01/06), KCP-0106, IEKC-0106, IF (01/06) and IFDO (01/06), 946001 (11/05)-PDF, 946001 (12/05), 956002 (02/03), PVA1454 (12/05), 946045 (11/05), 946045 (11/05)-PDF; policy form #s 901119-CP.1 et al., 901151-CP et al., ; Schedule of Benefits form #s PVA1231, AVA1513, PVA1723, PVA2326, AVA1515 and PVA1721; optional coverage form #s AVA1517, AVA1563, AVA1564, AVA1392, AVA1393, 901167, , and AVA1347; application form #s AVA1553 AVA1020, AVA1552 AVA1530 or AVA1631, AVA1529 or AVA1628, AVA1533 or AVA1632, AVA1536, or AVA1633, AVA1537,and AVA1572. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
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