mediCOVERAGE™
health insurance starts here

Company	Anthem BlueCross BlueShield		Anthem BlueCross BlueShield	
Plan Name	SmartSense		SmartSense with Enhanced Drug	
Apply	Apply		Apply	
Estimated Monthly Premium	Varies By Deductible		Varies By Deductible	
Plan Type	PPO		PPO	
Networks	See provider details		See provider details	
	Network	Non-Network	Network	Non-Network
Copay	$35		$35	
Deductible	750 to 10,000 (double for families)		750 to 10,000 (double for families)	
Coinsurance	30%	50%	30%	50%
Coinsurance Limit	see brochure		see brochure	
Out-of-Pocket Maximum	Individual: $4,250, Family: $8,500	Individual: $8,250, Family: $16,500	Individual: $4,250, Family: $8,500	Individual: $8,250, Family: $16,500
Lifetime Maximum	Unlimited		Unlimited	
Office Visit	Office Visits: Office Visit Copay for the first 3 yearly visits: $35 copay deductible waived, for primary care physician or specialist visits; Office Visit Coinsurance for remaining visits: 30% after deductible	Office Visits: 50% after deductible	Office Visits: Office Visit Copay for the first 3 yearly visits: $35 copay deductible waived, for primary care physician or specialist visits; Office Visit Coinsurance for remaining visits: 30% after deductible	Office Visits: 50% after deductible
Prescription Drugs	Retail Drugs and Mail Order Drugs when available; For Drugs on Formulary (Generic and Brand Name/Specialty Drugs): $15 copay deductible waived or 40% coinsurance, whichever is greater; For Drugs Not on Formulary: Not covered	Retail Drugs and Mail Order Drugs when available; For Drugs on Formulary (Generic and Brand Name/Specialty Drugs): $15 copay deductible waived or 40% coinsurance, whichever is greater; For Drugs Not on Formulary: Not covered; Member is responsible for filing the claim and for the difference between the pharmacy charge and allowable charge	Retail Drugs and Mail Order Drugs when available; For Generic and Brand Name Drugs: $15 copay or 40% coinsurance, whichever is greater; For Specialty Drugs: 40% coinsurance	Retail Drugs and Mail Order Drugs when available; For Generic and Brand Name Drugs: $15 copay or 40% coinsurance, whichever is greater; For Specialty Drugs: 40% coinsurance; Member is responsible for filing the claim and for the difference between the pharmacy charge and our allowable charge plus applicable copay or coinsurance
Emergency Room	Emergency Room (Medical Emergency or Accident): 30% after deductible; Emergency Room (Non-Medical Emergency or Non-Serious Accidental Injury): 30% after deductible; Ambulance Services: 30% after deductible	Emergency Room (Medical Emergency or Accident): 30% after deductible; Emergency Room (Non-Medical Emergency or Non-Serious Accidental Injury): 50% after deductible; Ambulance Services: 50% after deductible	Emergency Room (Medical Emergency or Accident): 30% after deductible; Emergency Room (Non-Medical Emergency or Non-Serious Accidental Injury): 30% after deductible; Ambulance Services: 30% after deductible	Emergency Room (Medical Emergency or Accident): 30% after deductible; Emergency Room (Non-Medical Emergency or Non-Serious Accidental Injury): 50% after deductible; Ambulance Services: 50% 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 50%; 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 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 50%; 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 Services - Preventive Care and Immunizations for Children age 6 and under (Includes coverage for office visits, lab tests, vision and hearing screenings and immunizations): 0% copay and deductible waived		Preventive Care Services - Preventive Care and Immunizations for Children age 6 and under (Includes coverage for office visits, lab tests, vision and hearing screenings and immunizations): 0% copay and deductible waived	
Lab/X-ray	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% after deductible	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 50% after deductible	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% after deductible	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 50% after deductible
Maternity	Complications of Pregnancy Only		Complications of Pregnancy Only	
Physical Therapy	Outpatient Physical/Occupational Therapy: Member pays 30% after deductible; Limitations (in and out of network combined) - 20 visits per member, per calendar year	Outpatient Physical/Occupational Therapy: Member pays 50% 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	Outpatient Physical/Occupational Therapy: Member pays 50% after deductible; Limitations (in and out of network combined) - 20 visits per member, per calendar year
Skilled Nursing	Skilled Nursing: 30% after deductible (100 day limit per year per person)	Skilled Nursing: 50% after deductible (100 day limit per year per person)	Skilled Nursing: 30% after deductible (100 day limit per year per person)	Skilled Nursing: 50% after deductible (100 day limit per year per person)

Home Health Care	Home Health Care: 30% after deductible (90 visit limit per year per person); Hospice: 30% after deductible	Home Health Care: 50% after deductible (90 visit limit per year per person); Hospice: 50% after deductible	Home Health Care: 30% after deductible (90 visit limit per year per person); Hospice: 30% after deductible	Home Health Care: 50% after deductible (90 visit limit per year per person); Hospice: 50% after deductible
Mental Health	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: Visits 1-3: Member pays $35 copay or 30% after deductible (deductible waived when there is a copay - applies to the 3 office visit copay limit) for office visit only; Visits 4-5: 30% after deductible; Visits 6-20: 50% after deductible	Mental Health and Substance Abuse - Inpatient: 50% after deductible (25 day limit per year per person; 10 Inpatient days can converted to 15 partial days); Outpatient: 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: Visits 1-3: Member pays $35 copay or 30% after deductible (deductible waived when there is a copay - applies to the 3 office visit copay limit) for office visit only; Visits 4-5: 30% after deductible; Visits 6-20: 50% after deductible	Mental Health and Substance Abuse - Inpatient: 50% after deductible (25 day limit per year per person; 10 Inpatient days can converted to 15 partial days); Outpatient: 50% after deductible
Hospital Care	Inpatient Services (overnight hospital/facility stays): 30% after deductible; Outpatient Services (overnight hospital/facility stays): 30% after deductible	Inpatient Services (overnight hospital/facility stays): 50% after deductible; Outpatient Services (overnight hospital/facility stays): 50% after deductible	Inpatient Services (overnight hospital/facility stays): 30% after deductible; Outpatient Services (overnight hospital/facility stays): 30% after deductible	Inpatient Services (overnight hospital/facility stays): 50% after deductible; Outpatient Services (overnight hospital/facility stays): 50% after deductible
Included Benefits	see brochure		see brochure	
Optional Benefits (not included in base rate quotation)				
Fees				
Policy Form Number	see brochure		see brochure	
Note	Optional Benefits: Supplemental Accident and Dental		Optional Benefits: Supplemental Accident and Dental	
Product Brochure	Brochure		Brochure	
Optional Riders included in the quote				
Optional Riders not included in the quote	❑ Dental : $23.00 ❑ Supplemental Accident : $12.00		❑ 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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Norvax form #DS-1