mediCOVERAGE™
health insurance starts here

Company	Anthem BlueCross	
Plan Name	ClearProtection Plus	
Apply	Apply	
Estimated Monthly Premium	Varies By Deductible	
Plan Type	PPO	
Networks	See provider details	
	Network	Non-Network
Copay	$40	N/A
Deductible	3300, 5000	
Coinsurance	40% (For Inpatient/Surgical and Emergency Room Services)	
Coinsurance Limit	see brochure	
Out-of-Pocket Maximum	Individual: $6,800, Family: $13,600 (this amount includes the deductible)	
Lifetime Maximum	Unlimited	
Office Visit	First 2 Office Visits (per member): $40 copay, deductible waived Additional Office Visits: 100% Coinsurance, then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible	100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible
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), for network only and in addition to $7,500 annual deductible	Retail Drugs (and Mail Order Drugs when available): Not Covered
Emergency Room	40% coinsurance plus $100 Emergency Room copay (copay waived if admitted overnight) after satisfying Inpatient/Surgical and Emergency Services deductible (in a medical emergency)	
Adult Preventive Care	0% coinsurance, not subject to either deductible (Includes preventive services recommended by the United State Preventive Services Task Focre, including immunizations, PSA screenings, pap tests, mammograms and more)	100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible (Includes preventive services recommended by the United State Preventive Services Task Focre, including immunizations, PSA screenings, pap tests, mammograms and more)
Child Preventive Care	0% coinsurance, not subject to either deductible (Includes preventive services recommended by the United State Preventive Services Task Focre, including well child care, immunizations and more)	100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible (Includes preventive services recommended by the United State Preventive Services Task Focre, including well child care, immunizations and more)
Lab/X-ray	Inpatient: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: 100% coinsurance, then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible	Inpatient: 50% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: 100% coinsurance, then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible
Maternity	Marternity services are covered as other services outlined in the covered services section of this benefit guide.	
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: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: 100% coinsurance, then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible Inpatient Services (overnight hospital/facility stays): 40% coinsurance after satisfying Inpatinet/Surgical and Emergency Room Services deductible Outpatient Services (without overnight hospital/facility stays) - Surgery: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Other Services: 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.) - Inpatient: 50% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: 100% coinsurance, then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible Inpatient Services (overnight hospital/facility stays): All charges except $650 per day after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient Services (without overnight hospital/facility stays) - Surgery: All charges except $380 per day after satisfying Inpatient/Surgical and Emergency Room Services deductible Other Services: 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible
Included Benefits	see brochure	
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. To view your Summary of Benefits and Coverage please visit www.healthcare.gov.	

Product Brochure	**Brochure**
Summary of Benefits and Coverage	
Optional Riders included in the quote	
Optional Riders not included in the quote	❑ Dental SelectHMO : $17.40 ❑ Dental Blue Basic : $28.00 ❑ Dental Blue Enhanced : $61.00

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 of California

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.

For all Medical applications received January 1, 2011 and later, the earliest policy effective date available will be 15 calendar days after receipt of the application.

Click here for important information about Applicants under the age of 19

To view your Summary of Benefits and Coverage please visit www.healthcare.gov (Not applicable for Short Term plans)