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	Primary Care: $30 Specialist: $40	30% Coinsurance
Deductible	500, 1500, 2500, 3500, 5000, 7500, 10,000 (double for families)	
Coinsurance	Please see brochure	30%
Coinsurance Limit	see brochure	
Out-of-Pocket Maximum	Please see brochure	Individual: $7,500, Family: $15,000 (Add your chosen deductible amount - For family plans with two or more members any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual member can contribute more than their individual deductible or out-of-pocket maximum)
Lifetime Maximum	None	
Office Visit	Office Visits (deductible waived): $30 Copay for primary care physician; $40 Copay for specialist	30% Coinsurance
Prescription Drugs	Retail Drugs (and Mail Order Drugs when available) - Generic and Brand-Name Drugs: $15 Copay or 40% Coinsurance, whichever is greater Specialty Drugs: 40% Coinsurance, up to a separate $10,000 annual Prescription Drug out-of-pocket maximum per member	Retail Drugs (and Mail Order Drugs when available): Same benefit as network, however, the 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		
Adult Preventive Care	0% Coinsurance, not subject to deductible (Covers nationally recommended preventive care for adults, PSA screenings, Pap tests, mammograms and more)	30% Coinsurance (Covers nationally recommended preventive care for adults, PSA screenings, Pap tests, mammograms and more)
Child Preventive Care	0% Coinsurance, not subject to deductible (Covers nationally recommended preventive care for children including immunizations and more)	30% Coinsurance (Covers nationally recommended preventive care for children including immunizations and more)
Lab/X-ray	20% Coinsurance	30% Coinsurance
Maternity	Not Covered (optional benefit available)	
Physical Therapy	Please see brochure	30% Coinsurance (20 visits per person per calendar year, in and out-of-network combined)
Skilled Nursing		30% Coinsurance (100 day limit per year per person, in and out-of-network combined)
Home Health Care		Home Health Care: 30% Coinsurance (100 visit limit per year per person, in and out-of-network combined) Hospice Care: 30% Coinsurance (Coverage if member is diagnosed as terminal with life expectancy of 6 months or less and who elect to receive palliative rather than curative care)
Mental Health	Not Covered	
Hospital Care	Please see brochure	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance Inpatient Services (overnight hospital/facility stays): 30% Coinsurance Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance
Included Benefits	see brochure	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	see brochure	
Note	Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other. 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		

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 New Hampshire

Other plan options and less expensive plan designs may be available. Please contact us, or your broker, for details.

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

Norvax form #DS-1