Company	Anthem	
Plan Name	ClearProtection	
Apply	Apply	
Estimated Monthly Premium	Varies By Deductible	
Plan Type	PPO	
Networks	See provider details	
	Network	Non-Network
Copay	$40	N/A
Deductible	1000, 3300, 5000 (double for families)	
Coinsurance	30%	50%
Coinsurance Limit	see brochure	
Out-of-Pocket Maximum	4500, 6500, 8500 (double for families)	
Lifetime Maximum	Unlimited	
Office Visit	First 2 Office Visits (per member): $40 Copay, deductible waived Additional Office Visits: 100% of negotiated fee; then 0% coinsurance after out-of-pocket maximum is met Inpatient: You pay 30% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: You pay 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible	100% coinsurance; then 0% coinsurance after out-of-pocket maximum is met
Prescription Drugs	Retail Drugs (and Mail Order Drugs when available) - Tier 1 (Generic drugs): $15 Copay $7,500 annual Prescription Drug deductible per member for Tier 2/Specialty drugs applies before the following - Tier 2 (Formulary Brand name drugs): $35 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 For Drugs Not on Formulary: Not covered, discount apply	Retail Drugs (and Mail Order Drugs when available): Same benefit as network plus any difference in cost between the actual charges and Anthem's allowed amount
Emergency Room	Inpatient: You pay 30% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: You pay 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible	
Adult Preventive Care	0% Coinsurance, not subject to deductible (Includes all nationally recommended preventive services including immunizations, PSA screenings, Pap tests, mammograms and more)	50% Coinsurance, deductible waived (Includes all nationally recommended preventive services including immunizations, PSA screenings, Pap tests, mammograms and more)
Child Preventive Care	0% Coinsurance, not subject to deductible (Includes all nationally recommended preventive services including well-child care, immunizations and more)	50% Coinsurance, deductible waived (Includes all nationally recommended preventive services including well-child care, immunizations and more)
Lab/X-ray	Inpatient: 30% Coinsurance Outpatient: 100% of negotiated fee; then 0% Coinsurance after out-of-pocket maximum is met	Inpatient: 50% Coinsurance Outpatient: 100% Coinsurance; then 0% Coinsurance after out-of-pocket maximum is met
Maternity	Not Covered	
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.): - Inpatient: You pay 30% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: You pay 100% coinsurance; then 0% after satisfying Outpatient/Professional and Diagnostic Services deductible Inpatient Services (overnight hospital/facility stays): You pay 30% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient Services (without overnight hospital/facility stays) - Surgery: You pay 30% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Other Services: You pay 100% coinsurance; then 0% after satisfying Outpatient/Professional and Diagnostic Services deductible	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): - Inpatient: 50% Coinsurance Outpatient: 100% Coinsurance; then 0% Coinsurance after out-of-pocket maximum is met Inpatient Services (overnight hospital/facility stays): 50% Coinsurance after Deductible, then 0% Coinsurance after out-of-pocket maximum is met Outpatient Services (without overnight hospital/facility stays): 100% Coinsurance after Deductible, then 0% Coinsurance after out-of-pocket maximum is met
Included Benefits	see brochure	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	see brochure	

Note	Deductibles - For Inpatient/Surgical and Emergency Room Services - Individual: $5,000, Family: $10,000 For Outpatient/Professional and Diagnostic Services - Individual: $8,500, Family: $17,000 Coinsurance - For Inpatient/Surgical and Emergency Room Services: 30% For Outpatient/Professional and Diagnostic Services: 0% Out-of-Pocket Maximum - For Inpatient/Surgical and Emergency Room Services - Individual: $3,500, Family: $7,000 (plus deductible) For Outpatient/Professional and Diagnostic Services - Individual: $0, Family: $0 (plus deductible) 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 Optional Autism Coverage Available - for more information please call Customer Service @ 1-877-494-3089 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

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.

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