| | | |
|---|---|---|
| **Company** | Anthem | |
| **Plan Name** | Premier | |
| **Apply** | Apply | |
| **Estimated Monthly Premium** | Varies By Deductible | |
| **Plan Type** | PPO | |
| **Networks** | See provider details | |
| | Network | Non-Network |
| **Copay** | $30 | N/A |
| **Deductible** | 1000, 2000, 3500, 5500, 7000 (double for families) | |
| **Coinsurance** | 25% | 50% |
| **Coinsurance Limit** | see brochure | |
| **Out-of-Pocket Maximum** | Individual: 2500 Family: 5000 | |
| **Lifetime Maximum** | Unlimited | |
| **Office Visit** | Office Visit $30 Copay for primary care physician; $50 Copay for specialist (deductible waived for both) | 50% Coinsurance (after deductible) |
| **Prescription Drugs** | Retail Drugs (and Mail Order Drugs when available) - Tier 1 (Generic Drugs): $15 Copay $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), network only and in addition to $500 annual deductible | Retail Drugs (and Mail Order Drugs when available): Same benefits as network, plus any difference in cost between the actual charges and Anthem's allowed amount |
| **Emergency Room** | 25% Coinsurance (after 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 (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 (Includes all nationally recommended preventive services including well-child care, immunizations and more) |
| **Lab/X-ray** | 25% Coinsurance (after deductible) | 50% Coinsurance (after deductible) |
| **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** | Inpatient Services (overnight hospital/facility stays): 25% after deductible Outpatient Services (without overnight hospital/facility stays): 25% after deductible | Inpatient Services (overnight hospital/facility stays): 50% after deductible Outpatient Services (without overnight hospital/facility stays): 50% after 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 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)

Norvax form #DS-1