HEALTHYGRADS
health insurance for recent grads

Healthygrads.com plan comparison

Company	Anthem		Anthem		Anthem	
Plan Name	SmartSense 3500 Standard Rx		SmartSense 2000 Standard Rx		SmartSense 1000 Upgrade Rx	
Apply	Apply		Apply		Apply	
Estimated Monthly Premium	Less expensive (Click here for quote)		Medium Priced (Click here for quote)		More Expensive (Click here for quote)	
Plan Type	PPO		PPO		PPO	
Networks	See provider details		See provider details		See provider details	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Copay	$30	N/A	$30	N/A	$30	N/A
Deductible	Individual: $3,500, Family: $7,000		Individual: $2,000, Family: $4,000		Individual: $1,000, Family: $2,000	
Coinsurance	30%	50%	30%	50%	30%	50%
Coinsurance Limit	see brochure		see brochure		see brochure	
Out-of-Pocket Maximum	Individual: $2,500, Family: $5,000 (plus deductible)	Individual: $8,500, Family: $17,000 (plus deductible)	Individual: $2,500, Family: $5,000 (plus deductible)	Individual: $7,000, Family: $14,000 (plus deductible)	Individual: $2,500, Family: $5,000 (plus deductible)	Individual: $6,000, Family: $12,000 (plus deductible)
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Office Visit	First 3 Office Visits (per member): $30 Copay, deductible waived Additional Office Visits: 30% Coinsurance (after deductible)	50% Coinsurance (after deductible)	First 3 Office Visits (per member): $30 Copay, deductible waived Additional Office Visits: 30% Coinsurance (after deductible)	50% Coinsurance (after deductible)	First 3 Office Visits (per member): $30 Copay, deductible waived Additional Office Visits: 30% Coinsurance (after deductible)	50% Coinsurance (after deductible)
Prescription Drugs	Standard Drug Coverage - 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), network only and in addition to $7,500 annual deductible	Standard Drug Coverage: Same benefits as network, plus any difference between the actual charges and Anthem's allowed amount	Standard Drug Coverage - 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), network only and in addition to $7,500 annual deductible	Standard Drug Coverage: Same benefits as network, plus any difference between the actual charges and Anthem's allowed amount	Upgrade Drug Coverage - 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	Upgrade Drug Coverage: Same benefits as network, plus any difference between the actual charges and Anthem's allowed amount
Emergency Room	30% Coinsurance (after deductible)		30% Coinsurance (after deductible)		30% 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)	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)	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)	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)	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	30% Coinsurance (after deductible)	50% Coinsurance (after deductible)	30% Coinsurance (after deductible)	50% Coinsurance (after deductible)	30% Coinsurance (after deductible)	50% Coinsurance (after deductible)
Maternity	Not Covered		Not Covered		Not Covered	
Physical Therapy	Benefits Included, see brochure for more coverage details		Benefits Included, see brochure for more coverage details		Benefits Included, see brochure for more coverage details	
Skilled Nursing	Benefits Included, see brochure for more coverage details		Benefits Included, see brochure for more coverage details		Benefits Included, see brochure for more coverage details	
Home Health Care	Benefits Included, see brochure for more coverage details		Benefits Included, see brochure for more coverage details		Benefits Included, see brochure for more coverage details	
Mental Health	Benefits Included, see brochure for more coverage details		Benefits Included, see brochure for more coverage details		Benefits Included, see brochure for more coverage details	

Questions? Visit www.healthygrads.com or call 800-930-7956

Hospital Care	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance (after deductible) Inpatient Services (overnight hospital/facility stays): 30% Coinsurance (after deductible) Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance (after deductible)	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 50% Coinsurance (after deductible) Inpatient Services (overnight hospital/facility stays): 50% Coinsurance (after deductible) Outpatient Services (without overnight hospital/facility stays): 50% Coinsurance (after deductible)	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance (after deductible) Inpatient Services (overnight hospital/facility stays): 30% Coinsurance (after deductible) Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance (after deductible)	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 50% Coinsurance (after deductible) Inpatient Services (overnight hospital/facility stays): 50% Coinsurance (after deductible) Outpatient Services (without overnight hospital/facility stays): 50% Coinsurance (after deductible)	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance (after deductible) Inpatient Services (overnight hospital/facility stays): 30% Coinsurance (after deductible) Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance (after deductible)	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 50% Coinsurance (after deductible) Inpatient Services (overnight hospital/facility stays): 50% Coinsurance (after deductible) Outpatient Services (without overnight hospital/facility stays): 50% Coinsurance (after deductible)
Included Benefits	see brochure		see brochure		see brochure	
Optional Benefits (not included in base rate quotation)						
Fees						
Policy Form Number	see brochure		see brochure		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		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		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	
Product Brochure	Brochure		Brochure		Brochure	
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.