HEALTHYGRADS
health insurance for recent grads

Healthygrads.com plan comparison

Company	Anthem. BlueCross BlueShield		Anthem. BlueCross BlueShield		Anthem. BlueCross BlueShield	
Plan Name	Premier 7500 Apply		Premier 5000 Apply		Premier 2500 Apply	
Estimated Monthly Premium	Less expensive (click here for quote)		Medium priced (click here for quote)		Most 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	Primary Care Physician: $30 Specialist: $40	30% Coinsurance	Primary Care Physician: $30 Specialist: $40	30% Coinsurance	Primary Care Physician: $30 Specialist: $40	30% Coinsurance
Deductible	Individual: $7,500, Family: $15,000		Individual: $5,000, Family: $10,000		Individual: $2,500, Family: $5,000	
Coinsurance	0%	30%	0%	30%	0%	30%
Coinsurance Limit	see brochure		see brochure		see brochure	
Out-of-Pocket Maximum	Individual: $0, Family: $0 (Add your chosen deductible to the 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)	Individual: $7,500; Family: $15,000 (Add your chosen deductible to the 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)	Individual: $0, Family: $0 (Add your chosen deductible to the 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)	Individual: $7,500; Family: $15,000 (Add your chosen deductible to the 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)	Individual: $0, Family: $0 (Add your chosen deductible to the 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)	Individual: $7,500; Family: $15,000 (Add your chosen deductible to the 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		None		None	
Office Visit	$30 Copay for primary care physician; $40 Copay for specialist (deductible waived)	30% Coinsurance	$30 Copay for primary care physician; $40 Copay for specialist (deductible waived)	30% Coinsurance	$30 Copay for primary care physician; $40 Copay for specialist (deductible waived)	30% Coinsurance
Prescription Drugs	Retail Drugs (and Mail Order Drugs when available) - Separate $200 deductible per member Tier 1 Drugs (deductible waived) - Retail (30-day supply): $15 Copay Mail Order (90-day supply): $30 Copay Tiers 2 and 3: 40% Coinsurance for either Retail (30-day supply) or Mail Order (90-day supply). Up to $10,000 annual Prescription Drug out-of-pocket maximum per member	Retail Drugs (and Mail Order Drugs when available) - Separate $200 deductible per member 50% Coinsurance up to the maximum allowable amount. Member is responsible for difference between Anthem allowable charge and actual cost of drug	Retail Drugs (and Mail Order Drugs when available) - Separate $200 deductible per member Tier 1 Drugs (deductible waived) - Retail (30-day supply): $15 Copay Mail Order (90-day supply): $30 Copay Tiers 2 and 3: 40% Coinsurance for either Retail (30-day supply) or Mail Order (90-day supply). Up to $10,000 annual Prescription Drug out-of-pocket maximum per member	Retail Drugs (and Mail Order Drugs when available) - Separate $200 deductible per member 50% Coinsurance up to the maximum allowable amount. Member is responsible for difference between Anthem allowable charge and actual cost of drug	Retail Drugs (and Mail Order Drugs when available) - Separate $200 deductible per member Tier 1 Drugs (deductible waived) - Retail (30-day supply): $15 Copay Mail Order (90-day supply): $30 Copay Tiers 2 and 3: 40% Coinsurance for either Retail (30-day supply) or Mail Order (90-day supply). Up to $10,000 annual Prescription Drug out-of-pocket maximum per member	Retail Drugs (and Mail Order Drugs when available) - Separate $200 deductible per member 50% Coinsurance up to the maximum allowable amount. Member is responsible for difference between Anthem allowable charge and actual cost of drug
Emergency Room	20% Coinsurance		20% Coinsurance		20% Coinsurance	
Adult Preventive Care	0% Coinsurance, not subject to deductible (Covers all nationally recommended preventive care for adult including PSA screenings, Pap tests, mammograms and more)	30% Coinsurance (Covers all nationally recommended preventive care for adult including PSA screenings, Pap tests, mammograms and more)	0% Coinsurance, not subject to deductible (Covers all nationally recommended preventive care for adult including PSA screenings, Pap tests, mammograms and more)	30% Coinsurance (Covers all nationally recommended preventive care for adult including PSA screenings, Pap tests, mammograms and more)	0% Coinsurance, not subject to deductible (Covers all nationally recommended preventive care for adult including PSA screenings, Pap tests, mammograms and more)	30% Coinsurance (Covers all nationally recommended preventive care for adult including PSA screenings, Pap tests, mammograms and more)
Child Preventive Care	0% Coinsurance, not subject to deductible (Covers all nationally recommended preventive care for children including immunizations and more)	30% Coinsurance (Covers all nationally recommended preventive care for children including immunizations and more)	0% Coinsurance, not subject to deductible (Covers all nationally recommended preventive care for children including immunizations and more)	30% Coinsurance (Covers all nationally recommended preventive care for children including immunizations and more)	0% Coinsurance, not subject to deductible (Covers all nationally recommended preventive care for children including immunizations and more)	30% Coinsurance (Covers all nationally recommended preventive care for children including immunizations and more)
Lab/X-ray	0% Coinsurance	30% Coinsurance	0% Coinsurance	30% Coinsurance	0% Coinsurance	30% Coinsurance
Maternity	Not Covered		Not Covered		Not Covered	
Physical Therapy	0% Coinsurance (20 visits per year per person, in and out-of-network combined)	30% Coinsurance (20 visits per year per person, in and out-of-network combined)	0% Coinsurance (20 visits per year per person, in and out-of-network combined)	30% Coinsurance (20 visits per year per person, in and out-of-network combined)	0% Coinsurance (20 visits per year per person, in and out-of-network combined)	30% Coinsurance (20 visits per year per person, in and out-of-network combined)

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

Skilled Nursing	0% Coinsurance (100 day limit per year per person, in and out-of-network combined)	30% Coinsurance (100 day limit per year per person, in and out-of-network combined)	0% Coinsurance (100 day limit per year per person, in and out-of-network combined)	30% Coinsurance (100 day limit per year per person, in and out-of-network combined)	0% Coinsurance (100 day limit per year per person, in and out-of-network combined)	30% Coinsurance (100 day limit per year per person, in and out-of-network combined)
Home Health Care	Home Health Care: 0% Coinsurance (Member can not pay more than 25%/$420 for Social Services - as stated in mandate; 100 visit limit per year per person, in and out-of-network combined) Hospice Care: 0% Coinsurance (Coverage is member is diagnosed as terminal with life expectancy of 6 months or less and who elect to receive palliative rather than curative care)	Home Health Care: 30% Coinsurance (Member can not pay more than 25%/$420 for Social Services - as stated in mandate; 100 visit limit per year per person, in and out-of-network combined) Hospice Care: 30% Coinsurance (Coverage is member is diagnosed as terminal with life expectancy of 6 months or less and who elect to receive palliative rather than curative care)	Home Health Care: 0% Coinsurance (Member can not pay more than 25%/$420 for Social Services - as stated in mandate; 100 visit limit per year per person, in and out-of-network combined) Hospice Care: 0% Coinsurance (Coverage is member is diagnosed as terminal with life expectancy of 6 months or less and who elect to receive palliative rather than curative care)	Home Health Care: 30% Coinsurance (Member can not pay more than 25%/$420 for Social Services - as stated in mandate; 100 visit limit per year per person, in and out-of-network combined) Hospice Care: 30% Coinsurance (Coverage is member is diagnosed as terminal with life expectancy of 6 months or less and who elect to receive palliative rather than curative care)	Home Health Care: 0% Coinsurance (Member can not pay more than 25%/$420 for Social Services - as stated in mandate; 100 visit limit per year per person, in and out-of-network combined) Hospice Care: 0% Coinsurance (Coverage is member is diagnosed as terminal with life expectancy of 6 months or less and who elect to receive palliative rather than curative care)	Home Health Care: 30% Coinsurance (Member can not pay more than 25%/$420 for Social Services - as stated in mandate; 100 visit limit per year per person, in and out-of-network combined) Hospice Care: 30% Coinsurance (Coverage is 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	Mental Health Care/Substance Abuse (as stated in mandate) - Inpatient: 0% Coinsurance Outpatient - Primary Care Physician: $30 Copay Specialist Care: $40 Copay	Mental Health Care/Substance Abuse (as stated in mandate) - Inpatient: 30% Coinsurance Outpatient - Primary Care Physician: 30% Coinsurance Specialist Care: 30% Coinsurance	Mental Health Care/Substance Abuse (as stated in mandate) - Inpatient: 0% Coinsurance Outpatient - Primary Care Physician: $30 Copay Specialist Care: $40 Copay	Mental Health Care/Substance Abuse (as stated in mandate) - Inpatient: 30% Coinsurance Outpatient - Primary Care Physician: 30% Coinsurance Specialist Care: 30% Coinsurance	Mental Health Care/Substance Abuse (as stated in mandate) - Inpatient: 0% Coinsurance Outpatient - Primary Care Physician: $30 Copay Specialist Care: $40 Copay	Mental Health Care/Substance Abuse (as stated in mandate) - Inpatient: 30% Coinsurance Outpatient - Primary Care Physician: 30% Coinsurance Specialist Care: 30% Coinsurance
Hospital Care	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 0% Coinsurance Inpatient and Diagnostic Services (overnight hospital/facility stays): 0% Coinsurance Outpatient Services (without overnight hospital/facility stays): 0% Coinsurance	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance Inpatient and Diagnostic Services (overnight hospital/facility stays): 30% Coinsurance Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 0% Coinsurance Inpatient and Diagnostic Services (overnight hospital/facility stays): 0% Coinsurance Outpatient Services (without overnight hospital/facility stays): 0% Coinsurance	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance Inpatient and Diagnostic Services (overnight hospital/facility stays): 30% Coinsurance Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 0% Coinsurance Inpatient and Diagnostic Services (overnight hospital/facility stays): 0% Coinsurance Outpatient Services (without overnight hospital/facility stays): 0% Coinsurance	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance Inpatient and Diagnostic Services (overnight hospital/facility stays): 30% Coinsurance Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance
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	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		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		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	
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.

Anthem Blue Cross and Blue Shield of Connecticut

No More Annual Maximums or Lifetime Dollar Limits: These plans will not include annual dollar limits or maximums on essential health benefits, or lifetime dollar limits or maximums. Expanded Dependent Coverage: Adult children can remain on your plan until their 26th birthday regardless of student or marital status.

Pre-Existing Condition Exclusion for Kids: There are no pre-existing condition limits for dependent children under the age of 19.

No Cost-Sharing on Preventive Care Services: These plans will not have any copayment, coinsurance or deductible requirement for in-network preventive care services recommended by the U.S. Department of Health and Human Services. This includes certain screenings, immunizations and physician visits for any covered member of your family.

New Patient Protection Benefits: Depending on the plan you are viewing, these benefits may already be included. No preauthorization will be required for emergency services, whether the emergency room is in- or out of network. If you need to use an out-of-network emergency room, you're covered, and copayments and coinsurance will not exceed the costs for in-network emergency room services.

If the plan requires that you select a Primary Care Physician (PCP), you may choose any available in-network physician and seek care from an in-network OB-GYN specialist provider without requiring a preauthorization or referral from your PCP. Preauthorization for specific obstetrical or gynecological services is still allowed and may be required. You can also choose a pediatrician as the PCP for your child.

Due to ongoing uncertainty, Anthem has made the decision to suspend the sale of child-only policies and policies where the primary subscriber is under 19 years of age, for effective dates of 9/23 or later.