



And find the added value your clients deserve.

Introducing Premier

Anthem Blue Cross follows up on our promise to continue to deliver new product options for your clients in 2010. The new Premier portfolio offers many benefits before the deductible and richer coverage for preventive care and prescription drugs. Featuring the lowest levels of coinsurance across all deductibles, Premier truly offers added value. Learn more about how Premier's choices can help you meet the needs of your prospects and clients.

New Premier Plan Highlights

- Unlimited doctor office visits with predictable copays, before the deductible.
- A broad range of preventive benefits help focus on keeping you healthy.
- Generic, brand and specialty drug coverage.
- Annual routine eye exam.
- \$7 million per member in lifetime benefits.

Premier features to consider

- Premier offers one of our highest levels of benefits, so premiums are typically more than our other plans.
- Maternity benefits are not included

Contract codes for plans	Contract Code
Premier 1000	01KU
Premier 1500	01KV
Premier 2500	01KW
Premier 3500	01L0
Premier 5000	01L1
Premier 6000	01L2

See the sample rate chart for a closer look

Monthly Rates for 30-year-old, 40-year-old and 50-year-old males	Premier 1000 Deductible			Premier 2500 Deductible			Premier 6000 Deductible		
	30	40	50	30	40	50	30	40	50
Age									
(Area 1)	\$259	\$333	\$487	\$169	\$214	\$341	\$136	\$169	\$274
(Area 2)	\$235	\$302	\$442	\$153	\$194	\$309	\$123	\$153	\$249
(Area 3)	\$230	\$296	\$433	\$150	\$190	\$303	\$120	\$150	\$244
(Area 4)	\$215	\$277	\$405	\$140	\$178	\$283	\$112	\$140	\$228

Premier is a great choice for families or individuals looking for robust benefits for both routine and unexpected medical care.

Preventive Care Reminders

Preventive care is an important component of the Premier plan coverage. An annual physical exam and certain preventive screenings are covered before the deductible, once members have been on the plan for six months.

Quoting is easy!

Quoting tools for Premier plans will be available on AgentConnect/PlanFinder March 1, for April 1 first effective dates.

How can members apply?

Fill out an online or paper application! Use the contract codes listed above.

Anthem Blue Cross Individual and Family Health Plans.

Benefits they want, preventive care they need – From a company your clients know and trust.

Benefits

Calendar Year Deductible

Individual	NETWORK:
	NON-NETWORK:
Family	NETWORK:
	NON-NETWORK:

Premier

Your Choices

Individual	NETWORK:	\$1,000	\$1,500	\$2,500	\$3,500	\$5,000	\$6,000
	NON-NETWORK:	\$1,000	\$1,500	\$2,500	\$3,500	\$5,000	\$6,000
Family	NETWORK:	\$2,000	\$3,000	\$5,000	\$7,000	\$10,000	\$12,000
	NON-NETWORK:	\$2,000	\$3,000	\$5,000	\$7,000	\$10,000	\$12,000
Network Coinsurance Options		25%	25%	25%	25%	25%	25%

Calendar Year Out-of-Pocket Maximum

Individual	NETWORK:
	NON-NETWORK:
Family	NETWORK:
	NON-NETWORK:

Add Your Chosen Deductible to the Amount Below

Individual	NETWORK:	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500
	NON-NETWORK:	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500
Family	NETWORK:	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000
	NON-NETWORK:	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000

How family deductibles and family out-of-pocket maximums work

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.

Plan Lifetime Maximum

Plan pays up to: \$7 million per member, network and non-network services combined

Covered Services

Your Share of Costs (after deductible, unless waived)

Doctors' Office Visits

NETWORK: Office Visit \$30 Copay for primary care physician; \$50 Copay for specialist (deductible waived for both)
NON-NETWORK: 50% Coinsurance

Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)

NETWORK: 25% Coinsurance
NON-NETWORK: 50% Coinsurance

Inpatient Services (overnight hospital/facility stays)

NETWORK: 25% Coinsurance
NON-NETWORK: 50% Coinsurance

Outpatient Services (without overnight hospital/facility stays)

NETWORK: 25% Coinsurance
NON-NETWORK: 50% Coinsurance

Emergency Room Services

NETWORK: 25% Coinsurance
NON-NETWORK: 25% Coinsurance

Preventive Care Services

NETWORK: HealthyCheckSM Centers (deductible waived): \$25 or \$75 Copay for basic or premium screening (for ages 7 and older)
For members covered more than 6 months^{1,2} (deductible waived for the following):
- Annual physical exam: \$30 Copay
- Routine mammogram, Pap and PSA tests: \$30 Copay
- Well-Child (through age 6): \$30 Copay
Colorectal cancer screening: 25% Coinsurance (after deductible)
NON-NETWORK: 50% Coinsurance

Maternity

Not Covered

Optional Coverage (at additional cost)

Dental, Life

Prescription Drug Coverage

Premier

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.
NON-NETWORK: Not Covered

Optional Drug Coverage (when available)

Not Applicable

Other Covered Benefits include but are not limited to:

Ambulance, Chiropractic Services, Home Health Care, Mental Health, Physical/Occupational Therapy, Urgent Care, Vision Exam

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Policy/EOC. In the event of a conflict between the Policy/EOC and this Benefit Guide, the terms of the Policy/EOC will prevail.

¹For members covered less than 6 months, services are covered after the deductible.
²\$200 annual maximum benefit for preventive care lab work (excluding mammogram, Pap and PSA tests).
NOTES:
- Discounted rates apply for network covered services.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.
- For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
- Copays/coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the policy.