

Group Quote Request Form (group size 2+)

Broker name		Broker number		Date submitted	Requested effective date
Type <input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Reinstatement		Current carrier		Association	
Rates: <input type="checkbox"/> Composite <input type="checkbox"/> Age/Sex					
Broker fax number	Broker phone number/email		Group name/group number		Group contact name/phone no.
Group address		City, State, ZIP code		Type of industry	SIC code

Blue AccessSM Hospital Surgical PPO Plan Cost Share Options

	Deductible (applies as noted) Single/Family	Network						Emergency Room Services	Non-Network			Prescription Drug Option
		Physician Home and Office Services	Inpatient Care Copayment/Coinsurance	Outpatient Surgery	All Other Covered Services Coinsurance unless otherwise stated	Professional Services: Inpatient Medical Care/ Outpatient Surgery	Out-of-Pocket Limit Single/Family		Deductible (applies to most care) Single/Family	All Covered Services unless otherwise stated	Out-of-Pocket Limit Single/Family	
Option hs1 <input type="checkbox"/>	\$1,000/\$3,000	\$20/50%	\$500/20%	20%	20%	20%	\$5,000/\$10,000	\$150/20%	\$2,000/\$6,000	50%	\$10,000/\$20,000	O
Option hs2 <input type="checkbox"/>	\$2,000/\$6,000	\$20/50%	\$750/20%	20%	20%	20%	\$5,000/\$10,000	\$150/20%	\$4,000/\$12,000	50%	\$10,000/\$20,000	O
Option hs3 <input type="checkbox"/>	\$2,500/\$7,500	\$20/50%	\$1,000/20%	20%	20%	20%	\$5,000/\$10,000	\$150/20%	\$5,000/\$15,000	50%	\$10,000/\$20,000	O
Option hs4 <input type="checkbox"/>	\$5,000/\$15,000	\$20/50%	\$1,000/20%	20%	20%	20%	\$10,000/\$20,000	\$150/20%	\$10,000/\$30,000	50%	\$20,000/\$40,000	O

0% means no copayment/coinsurance up to the maximum allowable amount. Additional copayments, coinsurance and limits apply and may vary by option selected. Refer to the benefit summary for detailed information.

Notes:

- Deductible(s) apply to covered medical services except for office visits, emergency room services, and Inpatient Care Services where a flat dollar amount and a percentage (%) coinsurance applies.
- Inpatient Care includes Inpatient admissions for Surgery, Maternity Care and Skilled Nursing Facility Care.
- Physician Home and Office Services exclude certain diagnostic tests such as MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Allergy Testing.
- Outpatient Surgery includes Surgery and related services associated with the surgery, chemotherapy, radiation therapy, infusion therapy and dialysis treatment (excluding preventive services).
- All Other Covered Services include state mandates, Outpatient Diagnostic Services and Physical, Medicine and Rehabilitation, Physical Medicine Therapy through Day Rehabilitation programs, Ambulance Service, Home Care Services (excluding Private Duty Nursing), Hospice Care, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and Ultrasounds.
- Immunizations through age 9 – No Cost Share up to the maximum allowable amount (office visit charge not covered) (Network and Non-network)

Anthem ByDesign Buy-up Notes:

- Select one Buy-up Option (mark a "B" in the box next to the option number).
- Select one Core Option (mark a "C" in the box next to the option number).
- Work with your Anthem Sales Representative or Underwriting to maintain at least a 10 percent and no more than 60 percent pricing spread between the Core and the Buy-up option.
- Only applies to Blue Access PPO.

This benefit summary is intended to be a brief outline of coverage and is not intended to be a legal contract. Please refer to your benefit plan document for details concerning benefits, procedures and exclusions.

Group Name:

Prescription Drug

Prescription Drug Option	Network Retail	Network Mail Service	Non-network
O	\$10 generic /100% brand*	\$20 generic/100% brand*	50% generic/100% brand*

*Rx Option O – Brand prescription drugs are 100% member cost share.

Rx Notes:

- 30-day supply for **Network and Non-network** pharmacy (does not include drugs obtained through mail service pharmacy).
- Certain diabetic and asthmatic supplies available at **Network** pharmacies. (Not covered at **Non-network** pharmacies.) Diabetic test strips paid same as any other drug (**Network and Non-network**).

Anthem Rx Mail Service:

- 90-day supply
- **Non-network** not covered.

All Health Options include the following:

- All medical deductibles and percentage (%) coinsurance apply toward the out-of-pocket limit (excluding **Non-network** Human Organ and Tissue Transplant (HOTT) Services).
- **Network** and **Non-network** deductibles, copayments, coinsurance and out-of-pocket limits are separate and do not accumulate toward each other.
- **Ambulance and Hospice** paid at the **Network** level.
- \$2 million lifetime maximum for all covered medical services (**Network and Non-network combined**). However, once the medical lifetime maximum is met, no additional prescription drug claims will be paid.
- Benefit period = calendar year.
- Prescription Drug Card program includes chemotherapeutic agents and immunosuppressants at the appropriate generic copayment.
- State mandates covered subject to place of service cost share unless otherwise stated.

Skilled Nursing Facility (Network and Non-network combined):
Limited to 90 days per calendar year.

Home Care Services (Network and Non-network combined):
Limited to 60 visits per calendar year.

Behavioral Health Services:
Biological based services covered based on place of service cost sharing.
Alcoholism (network and non network combined): Limited up to \$550 per calendar year

Inpatient Physical Medicine and Rehabilitation (Network and Non-network combined):
Limited to 60 days per calendar year, includes Day Rehabilitation programs.

Outpatient Diagnostic Services (Network and Non-network combined):
\$300 per calendar year (excludes state mandated services and inpatient care).

Human Organ and Tissue Transplants:
Network/Non-network: Subject to Cost Share based on place of service up to the maximum allowable amount.
Non-network: Does not apply to out-of-pocket limits.

Kidney and cornea transplants are paid the same as any other medical covered benefit.

100+ group size only:

Dependent Eligibility			
End of Calendar Year	End of Month	To Birthday	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 18; 23, federal tax exemption
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19 only
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19; 21, full-time student
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19; 23, full-time student
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19; 24, full-time student
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age 19; 25, full-time student

Note: Bolded text is the standard Dependent Eligibility.

51+ group size only:

Medicare Rx Options	
<input type="checkbox"/>	Wrap
<input type="checkbox"/>	Subsidy*
<input type="checkbox"/>	Waiver

*Subsidy is only available to 100+ size groups.

100+ group size only:

<input type="checkbox"/>	Case Exception applies
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