Individual and Family Health Care Plans
for Ohio

Our plans fit your plans

Lumenos® HSA
CoreShare℠
Blue Access® Value

OHBR0015578BCL (12/09)

Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain. You can benefit from the reliability and protection of health care coverage. Whether you're self-employed, need coverage for your family, just left group coverage, or your job doesn't provide it, Anthem Blue Cross and Blue Shield offers dependable individual health care plans that help save you time and make sense for the way you live.

You're in charge of your health and budget, and our plans help keep it that way. Check out our wide range of benefit options and if you have any questions, we are here to help. Dependable, valuable protection that fits the way you live. Sounds like a plan.

Experience you can rely on

As one of the most trusted names in health coverage, Anthem has been providing health care coverage and security to Ohio for over 70 years. We're committed to helping simplify your life and improving your health. In addition, we offer:

- One of the largest provider networks in Ohio. With more than 41,000 Ohio health practitioners and over 165 hospitals throughout the state, chances are your doctor is in our network.
- A choice of plans to fit your budget and lifestyle. No matter where you are in life, we've got a plan designed to fit your health coverage needs, as well as your budget.
- Optional dental and life insurance. To enhance your health, we also offer dental and term life coverage and make it easy to enroll.
- Coverage that travels with you. No matter where life takes you, your health coverage goes with you. And network providers in the BlueCard® program across the country will help make it easy to get access to the care you need.

Why do you need health care coverage?

These days, a single day in the hospital can cost thousands of dollars. The financial risk you take without health coverage just isn't worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you're protected against the high cost of unexpected medical bills.

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 41,000 practitioners and over 165 hospitals and other facilities, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

Cost–Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the cost, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copayment is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for in-network covered services. Once you reach this maximum, the plan pays at 100% for most services for the rest of the calendar year.

Lifetime Maximum is the lifetime benefit amount that will be paid under the policy for each member. This includes network and non-network covered services combined.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

Brand Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Tiers represent a cost level within the generic and brand name prescription drug categories. The prescription drug coverage under your health care plan will differ for each of these tiers. Not all products have this tiering.

- **Tier 1:** These drugs generally include generic drugs and a few lower cost brand name drugs.
- **Tier 2:** These drugs generally include higher cost generic and brand name drugs.
- **Tier 3 and 4:** These drugs include the highest cost brand name drugs.

Formulary is a list of prescription drugs our health care plans cover. They include generic and preferred brand name drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans. Formulary lists can be found at anthem.com.

Health Savings Account (HSA) is a special bank account that can be set up by a member enrolled in a qualified HSA-compatible high-deductible health plan if they choose. Contributions to this account can be made with certain tax advantages and funds from the account can be used for qualified health care expenses. See the insert from our preferred banking partner for more details and consult your tax advisor.

Lumenos® HSA Is this the right plan for you?

Lumenos HSA health plans were designed to give you more control over your health care costs. They help you focus on getting healthy and staying that way.

Lumenos HSA Plan Highlights

This plan offers traditional health care benefits that can be paired with a Health Savings Account (HSA) for more flexibility and potential tax advantages. Simple plan designs make using them that much easier.

Features:

- A choice of benefit options, including those that offer 100% for covered preventive care before the deductible.
- PPO health plan coverage with a large array of benefits after you pay your deductible.
- Coverage compatible with an HSA that is yours to fund and keep if you choose. Use the HSA for qualified medical expenses or as a savings vehicle. Just contact your tax advisor for possible advantages.
- Special programs for Smoking Cessation and Weight Management.
- Access to our 24-hour Nurse Line.
- Online tools for a personalized Health Assessment, prescription drug cost comparison, and other tools to give you more control.

You should know:

- Your Lumenos HSA plan has a policy-level deductible and out-of-pocket maximum. Once any combination of covered members on the policy meet these amounts, the plan pays 100% of covered expenses. It's that simple.
- While Lumenos HSA is compatible with a Health Savings Account, your health care plan works with or without it. You may set up the HSA now, later, or not at all. It's your choice.

Lumenos HSA Preventive Care

Because staying healthy is just as important as getting better, there are a number of options you can choose that offer 100% coverage for preventive care with no deductions from your Health Savings Account and lower your out-of-pocket costs when you use a network provider.

Prescription Drug Coverage

Lumenos not only puts you in charge of your health care dollars, it can help you use those dollars for generic and brand name prescription drugs in the way that best suits you.

Once your deductible is met, there is a coinsurance, if applicable, for covered prescription drugs. But even while you are meeting your deductible, you benefit from lower negotiated rates on prescription drugs at network pharmacies nationwide. There's no need to have a different deductible or copayment for prescriptions; it all works as one.

And since you decide how to spend it, your Health Savings Account dollars can be used to pay for prescription drugs – either while you are meeting your deductible, or afterward for those drugs not covered, like most over–the–counter medications.

How to Customize your Lumenos HSA Plan

Choose your deductible: Lumenos HSA deductibles range from $1,500 to $5,500 for individuals or $3,000 to $11,000 for families. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you. Remember, any covered member can contribute to some or all of the policy deductible and out–of–pocket maximum, whether the policy covers one member or a whole houseful.

Use your Health Savings Account the way you want: Your HSA, if you choose to open one, is funded by you. So, it is yours to use for qualified health care expenses covered by the plan, or those not covered at all, like contact lenses. Your HSA is also yours to keep if you ever leave the plan; you won't lose those dollars if they're not used. In fact, the carryover from year to year can help you save for future financial needs. See the enclosed insert from our preferred banking partner for more information.

Other Optional Coverage: You can add more protection for you and your family by purchasing optional maternity benefits, dental, and life insurance. See your Benefit Guide and the dental and life information in the back of this brochure for more details.

Anthem

Benefit Guide for Ohio

Benefits	Lumenos® HSA						
Calendar Year Deductible	**Your Choices**						
Individual NETWORK:	$1,500	$1,750	$2,500	$3,000	$3,500	$5,000	$5,500
Individual NON-NETWORK:	$1,500	$1,750	$2,500	$3,000	$3,500	$5,000	$5,500
Family NETWORK:	$3,000	$3,500	$5,000	$6,000	$7,000	$10,000	$11,000
Family NON-NETWORK:	$3,000	$3,500	$5,000	$6,000	$7,000	$10,000	$11,000
Network Coinsurance Options	0% or 50%	20%	0%	0%	0%	0%	0%
Calendar Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**						
Individual NETWORK:	$0 or $2,500	$3,250	$0	$0	$0	$0	$0
Individual NON-NETWORK:	$1,500 or $6,500	$8,250	$2,500	$3,000	$3,500	$5,000	$5,500
Family NETWORK:	$0 or $5,000	$6,500	$0	$00	$0	$0	$0
Family NON-NETWORK:	$3,000 or $13,000	$16,500	$5,000	$6,000	$7,000	$10,000	$11,000

Benefits	Lumenos® HSA
How family deductibles and family out-of-pocket maximums work	For family coverage, either one or more members must meet the family deductible before any covered services that are subject to the deductible will be paid by the plan. The family out-of-pocket maximum can be met by either one or more members. Once the maximum is met, no additional coinsurance will be required for the family for the remainder of the calendar year.
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: 50%, 20% or 0% Coinsurance[1] NON-NETWORK: 50%, 40% or 40% Coinsurance[1]
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	NETWORK: 50%, 20% or 0% Coinsurance[1] NON-NETWORK: 50%, 40% or 40% Coinsurance[1]
Inpatient Services (overnight hospital/facility stays)	NETWORK: 50%, 20% or 0% Coinsurance[1] NON-NETWORK: 50%, 40% or 40% Coinsurance[1]
Outpatient Services (without overnight hospital/facility stays)	NETWORK: 50%, 20% or 0% Coinsurance[1] NON-NETWORK: 50%, 40% or 40% Coinsurance[1]
Emergency Room Services	NETWORK: 50%, 20% or 0% Coinsurance[1] NON-NETWORK: 50%, 20% or 0% Coinsurance[1]
Preventive Care Services	Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more. NETWORK: 50%, 20% or 0% Coinsurance[1] (deductible waived with $1,500/0%, $3,000/0% and $5,000/0%) NON-NETWORK: 50%, 40% or 40% Coinsurance[1] Note: The network deductible is waived for well-child care including immunizations for children from birth to age 9 for all plans. Benefits are limited for some plans to $500 maximum from birth to 12 months, and to $150 maximum per year for ages 1 - 9 (network and non-network combined). This limit applies to the $1,750/20%, $2,500/0%, $3,500/0% and $5,500/0% plans only.
Maternity	Not Covered (see Optional Coverage below)
Optional Coverage (at additional cost)	Dental, Life, Maternity (optional maternity rider available for plans with deductibles of $2,500 and greater; subject to 270-day waiting period)
Prescription Drug Coverage	**Lumenos HSA**
Retail Drugs (and Mail Order Drugs when available)	NETWORK: 50%, 20% or 0% Coinsurance[1] NON-NETWORK: 50%, 40% or 40% Coinsurance[1]
Optional Drug Coverage (when available)	Not Available
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic, Durable Medical Equipment, Home Health Care, Hospice Care, Mental Health, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Substance Abuse, Therapy Services, Urgent Care
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 Contract/Certificate of Coverage. In the event of a conflict between the Contract/Certificate of Coverage and this Benefit Guide, the terms of the Contract/Certificate of Coverage will prevail.	[1] Coinsurance is designated by the plan you choose. NOTE: Network and non-network deductibles are separate and do not accumulate towards each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate towards each other.

CoreShare℠ Is this the right plan for you?

CoreShare offers a simple plan design at one of our lowest costs. When considering CoreShare, please note that your share of the cost for covered services is typically higher than with our other plans — this cost-sharing helps lower your monthly premium. The overall premium savings work well if you are looking for financial protection against unexpected medical costs.

CoreShare Plan Highlights

CoreShare health care plan can be ideal for individuals who primarily want protection.

Features:

- A wide array of covered services including doctors' office visits, hospital, surgical, and outpatient care.
- Access to Anthem's discounts for covered health care services lower your costs even while you are sharing that cost with us.
- Out-of-pocket maximum gives you maximum level of financial responsibility. After you reach this limit, your covered services are usually paid at 100% for the remainder of the calendar year.

You should know:

- Maternity benefits are not available with this plan.
- Your coinsurance for most services is 50%, unless you choose one of the higher deductibles.

CoreShare Preventive Care

CoreShare offers basic preventive coverage, including services such as childhood immunizations, Pap and PSA tests, and mammograms.

Prescription Drug Coverage

The rising costs of prescription drugs is becoming harder to swallow. CoreShare includes coverage before your plan deductible for generic and select brand name drugs. You simply pay a copayment or coinsurance depending on the drug.

See your Benefit Guide for more details.

How to Customize your CoreShare Plan

With CoreShare, you have some choice and flexibility to change the plan to better meet your needs. CoreShare offers a choice of:

Deductible: CoreShare deductibles range from $750 to $25,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Facility Copayment: If you choose a higher deductible, you can eliminate the facility copayment requirement from your CoreShare plan. Otherwise, there is a copayment that will apply for inpatient hospital stays and outpatient surgeries.

Other Optional Coverage: Protect your smile and your wallet with optional dental and life insurance. See your Benefit Guide and the dental and life information in the back of this brochure for more details.

Anthem

Benefit Guide for Ohio

Benefits	CoreShare[SM]								
Calendar Year Deductible	**Your Choices**								
Individual NETWORK:	$750	$1,500	$2,500	$3,500	$5,000	$7,500	$10,000	$15,000	$25,000
Individual NON-NETWORK:	$750	$1,500	$2,500	$3,500	$5,000	$7,500	$10,000	$15,000	$25,000
Family NETWORK:	$1,500	$3,000	$5,000	$7,000	$10,000	$15,000	$20,000	$30,000	$50,000
Family NON-NETWORK:	$1,500	$3,000	$5,000	$7,000	$10,000	$15,000	$20,000	$30,000	$50,000
Network Coinsurance Options	50%	50%	50%	50%	50%	0%	0%	0%	0%
Calendar Year Out-of-Pocket Maximum	**Your Deductible Plus**								
Individual NETWORK:	$3,500	$3,500	$3,500	$3,500	$3,500	$0	$0	$0	$0
Individual NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family NETWORK:	$7,000	$7,000	$7,000	$7,000	$7,000	$0	$0	$0	$0
Family NON-NETWORK:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000

How family deductibles and family out-of-pocket maximums work	Each family member has an individual deductible and out-of-pocket maximum. The family deductible and out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual deductible or out-of-pocket maximum.
Plan Lifetime Maximum	Plan pays up to: $2 million per member, network and non-network services combined
Covered Services	**Your Share of Costs** (after deductible, unless waived)
Doctors' Office Visits	NETWORK: **50% or 0% Coinsurance**[1] NON-NETWORK: **50% or 30% Coinsurance**[1]
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	NETWORK: **50% or 0% Coinsurance**[1] NON-NETWORK: **50% or 30% Coinsurance**[1]
Inpatient Services (overnight hospital/facility stays)	NETWORK: **50% Coinsurance** PLUS **$750 Facility Copayment**[2] (with $750, $1,500, $2,500, $3,500, $5,000) **0% Coinsurance** (with $7,500, $10,000, $15,000, $25,000) NON-NETWORK: **50% Coinsurance** PLUS **$750 Facility Copayment**[2] (with $750, $1,500, $2,500, $3,500, $5,000) **30% Coinsurance** (with $7,500, $10,000, $15,000, $25,000)
Outpatient Services (without overnight hospital/facility stays)	NETWORK: **50% Coinsurance** PLUS **$200 Facility Copayment**[2] for outpatient surgeries performed at a medical facility (with $750, $1,500, $2,500, $3,500, $5,000) **0% Coinsurance** (with $7,500, $10,000, $15,000, $25,000) NON-NETWORK: **50% Coinsurance** PLUS **$200 Facility Copayment**[2] for outpatient surgeries performed at a medical facility (with $750, $1,500, $2,500, $3,500, $5,000) **30% Coinsurance** (with $7,500, $10,000, $15,000, $25,000)
Emergency Room Services	NETWORK: **50% or 0% Coinsurance**[1] NON-NETWORK: **50% or 0% Coinsurance**[1] Member is responsible for amount that exceeds Anthem allowable charge.
Preventive Care Services	Includes well-child care, immunizations, Pap tests and mammograms. Well-Child Care (network deductible waived): From birth to 12 months, $500 maximum; from age 1 to 9, $150 maximum per year; limits are combined for network and non-network services. NETWORK: **50% or 0% Coinsurance**[1] NON-NETWORK: **50% or 30% Coinsurance**[1]
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life
Prescription Drug Coverage	**CoreShare**
Retail Drugs (and Mail Order Drugs when available)	NETWORK or NON-NETWORK: · **For Drugs on Formulary:** Greater of **$15 Copayment or 40% Coinsurance** · **For Drugs Not on Formulary:** Member is responsible for entire cost after applied Anthem negotiated discount NON-NETWORK: · Member is responsible for entire cost.
Optional Drug Coverage (when available)	Not Available
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic, Durable Medical Equipment, Home Health Care, Hospice Care, Mental Health Services[3], Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Speech Therapy, Urgent Care

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[1] Coinsurance is designated by the plan you choose.

[2] Balance of charges subject to deductible and coinsurance. Facility Copayment does not accumulate towards the deductible or out-of-pocket maximum. Facility Copayment is still required even if out-of-pocket maximum has been met.

[3] Biologically based Mental Illnesses are covered the same as any illness. Limits do not apply. Inpatient substance abuse and non-biologically based mental health: 10 days maximum per benefit period for network and non-network combined. Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime with a $550 benefit period for network and non-network combined.

Note: Copayment/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the policy.

Blue Access® Value Is this the right plan for you?

Blue Access Value offers protection against the high costs of hospital care, as well as some conventional health care needs such as limited preventive care, two Doctors' Office Visits annually before the deductible, and more.

Blue Access Value Plan Highlights

Blue Access Value health care plan can be ideal for individuals who want affordable hospital coverage and a few more benefits for every day.

Features:

- Hospital coverage for inpatient stays and outpatient surgery.
- Coverage for your first two Doctors' Office Visits before the deductible with a predictable $35 copayment.
- Additional coverage for prescription drugs with a copayment.
- Up to $300 in outpatient diagnostic services such as X-rays and lab work.

You should know:

- Doctors' Office Visits after the first two are not covered.
- Maternity benefits are not available with this plan.

Blue Access Value Preventive Care

When you use our network, you receive benefits for immunizations, mammograms, Pap and PSA tests, and colorectal cancer screenings.

Prescription Drug Coverage

To give you some breathing room from the high costs of prescription drugs, the Blue Access Value Plan covers generic drugs with a copayment of just $10. Prescription benefits also include predictable copayments for brand name medications.

There is a separate prescription drug deductible and an annual benefit maximum on prescription benefits.

See your Benefit Guide for more details.

You Have Choices with your Blue Access Value Plan

With Blue Access Value, you have some choice and flexibility to change the plan to better meet your needs. Blue Access Value offers a choice of:

Deductible: Blue Access Value deductibles range from $2,000 to $10,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Other Optional Coverage: Get more protection for your smile and your wallet with optional dental and life insurance. See your Benefit Guide and the dental and life information in the back of this brochure for more details.

Benefits		Blue Access® Value			
Calendar Year Deductible		**Your Choices**			
Individual	NETWORK:	$2,000	$3,000	$5,000	$10,000
	NON-NETWORK:	$4,000	$6000	$10,000	$20,000
Family	NETWORK:	$4,000	$6,000	$10,000	$20,000
	NON-NETWORK:	$8,000	$12,000	$20,000	$40,000
Network Coinsurance Options		30%	30%	30%	30%
Calendar Year Out-of-Pocket Maximum		**Add Your Chosen Deductible to the Amount Below**			
Individual	NETWORK:	$3,000	$3,000	$3,000	$3,000
	NON-NETWORK:	$6,000	$6,000	$6,000	$6,000
Family	NETWORK:	$6,000	$6,000	$6,000	$6,000
	NON-NETWORK:	$12,000	$12,000	$12,000	$12,000
How family deductibles and family out-of-pocket maximums work		Each family member has an individual deductible and out-of-pocket maximum. The family deductible and out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual deductible or out-of-pocket maximum.			
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 Copayment for first 2 visits:** **$30 Copayment,** deductible waived, visits 3+ are not covered. · **Other Covered Services:** **30% Coinsurance** **NON-NETWORK:** · **Office Visit Coinsurance for first 2 visits only:** **40% Coinsurance,** deductible waived, visits 3+ are not covered. · **Other Covered Services:** **40% Coinsurance**
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** **30% Coinsurance** (deductible waived) **NON-NETWORK:** **40% Coinsurance** (deductible waived) Note: $300 annual benefit maximum for diagnostic services per member, network and non-network combined (Includes lab work, X-rays, and Outpatient Diagnostic Services. Preventive services are excluded from the $300 limit.)
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** **30% Coinsurance**[1] **NON-NETWORK:** **40% Coinsurance**
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** **30% Coinsurance** **NON-NETWORK:** **40% Coinsurance**
Emergency Room Services	**NETWORK:** **30% Coinsurance** (plus **$60 Copayment** if not admitted) **NON-NETWORK:** **30% Coinsurance** (plus **$60 Copayment** if not admitted)
Preventive Care Services	Includes Lab/X-ray for routine Pap test, annual mammogram, colorectal cancer screening or PSA screening ONLY. Other preventive tests are not covered. Well-Child Care: From birth to 12 months; $500 maximum per year; from age 1 to 9, $150 maximum per year; limits are combined for network and non-network services. **NETWORK:** **30% Coinsurance** **NON-NETWORK:** **40% Coinsurance**
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life

Prescription Drug Coverage	Blue Access Value
Retail Drugs (and Mail Order Drugs when available)	Maximum Annual Benefit is $500 per person. **NETWORK:** Separate $200 annual per person deductible for brand-name drugs on formulary **Generic Drugs on Formulary**: Retail (30 day supply) **$10 Copayment**; Mail order (90 day supply) **$20 Copayment** **Brand Name Drugs**: Retail (30 day supply) **$25 Copayment**; Mail order (90 day supply) **$50 Copayment** **Generic Drugs, Non-Formulary**: Retail (30 day supply) **$10 Copayment**; Mail order (90 day supply) **$20 Copayment** **Brand Name Drugs, Non-Formulary**: **Not covered** **NON-NETWORK:** **Not covered**
Optional Drug Coverage (when available)	Not Available
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic, Prosthetic Limbs, Home Health Care, Hospice Care, Mental Health, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Substance Abuse, Therapy Services in a Home Care Setting, Urgent Care
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Give yourself every advantage...

Good health and a bright smile.

Dental Blue® Plans

Regular dental check-ups and cleanings are important to your overall health. That's why we give you the option of adding one of these Dental Blue plans to your health coverage:

1. **Dental Blue Basic 100:** Gives you coverage for the basics, like routine check-ups and fillings. If your dental needs are simple, this may be the right plan for you.
2. **Dental Blue Essential 100:** Includes coverage for the basics, plus services like crowns, bridges, root canals and dentures. If you think you may need major dental work, this is the right plan for you.
3. **Dental Blue Essential 200:** Has basically the same coverage as Essential 100, but this plan also gives you wider choice of network dentists in exchange for a slightly higher cost. If your favorite dentist is in our larger network, this plan may be the best choice for you.

How dental networks help you save

While all three Dental Blue plans allow you to go to any dentist, you'll save the most money when you choose a dentist from your plan's network. There are two Dental Blue networks:

- **Dental Blue 100 network:** This is the value network for our Dental Blue 100 plans. Dental Blue Basic 100 and Essential 100 members can save the most on dental care when they choose a dentist from this network.
- **Dental Blue 200 network:** Includes the entire 100 network plus even more choices of dentists and specialists. Dental Blue Essential 200 members can save the most on dental care when they choose a dentist from this network.

How to choose the dental plan that works best for you.

Use the chart below to compare dental plan benefits side by side.

Plan Names	Dental Blue Basic 100	Dental Blue Essential 100	Dental Blue Essential 200	All Plans*
Networks	Dental Blue 100	Dental Blue 100	Dental Blue 200 (which includes all Dental Blue 100 dentists)	Benefit from negotiated rates at Dental Blue providers.
Preventive and Diagnostic care	100% covered within plan network. Includes routine checkups, X-rays and fluoride applications for children.	100% covered within plan network. Includes Basic 100 services plus space maintainers.		No waiting period; no deductible in or out-of-network; covers two routine cleanings and oral exams per year; molar/bicuspid X-rays; full mouth X-rays covered once every five years.
Minor restorative dental care	80% covered within plan network and pays set amount out-of-network after $50 deductible.* Includes fillings and space maintainers. Extractions not covered.	Pays set amount within plan network and out-of-network after $50 deductible.* Includes fillings and extractions. Space maintainers are considered preventive/diagnostic care.		No waiting period.
Major restorative dental care	Not covered	Pays set amount within plan network and out-of-network after $50 deductible.* Includes crowns, bridges, root canals and dentures.		12-month waiting period with Dental Blue Essential plan options.

*Per member, per calendar year
All plans include discounts on non-covered services like teeth whitening and orthodontia. This is only a summary of Dental Blue benefits. For complete benefit details, please refer to your Individual Dental Contract.

Optional Term Life Insurance

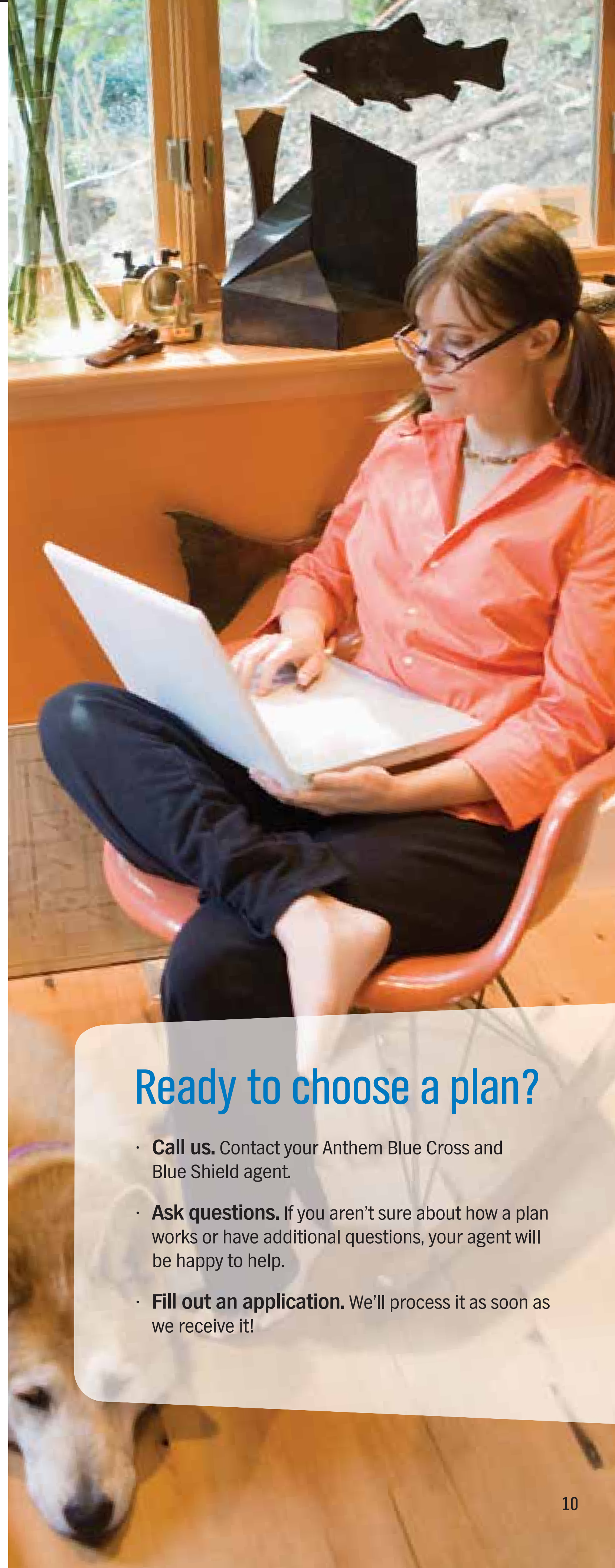
You can add Anthem Blue Preferred® Term Life Insurance to your health coverage. It's easy. There are no medical exams or extra forms to fill out. Simply use your application to apply for coverage.

Term Life Monthly Rates			
Age	$15,000	$25,000	$50,000
1-18	$1.50	$2.50	N/A
19-29	$2.85	$4.75	$9.50
30-39	$3.30	$5.50	$11.00
40-49	$7.50	$12.50	$25.00
50-59	$20.85	$34.75	$69.50
60-64	$29.40	$49.00	$98.00

Additional information

Save time with automatic premium payments

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.



Ready to choose a plan?

- **Call us.** Contact your Anthem Blue Cross and Blue Shield agent.
- **Ask questions.** If you aren't sure about how a plan works or have additional questions, your agent will be happy to help.
- **Fill out an application.** We'll process it as soon as we receive it!

Health. **Join In.**

Individual and Family Health Care Plans
for **Ohio**

Individual health coverage. Your plans. Your choices.

Make sure you have all the facts.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan[s] described — including what's covered, and what isn't. For full information about exclusions, limitations, and terms of this coverage, please see the enclosed Disclosure Document and Benefit Guide. These documents should be included with your information kit, or if you have printed this from your computer, they should be at the end of this document. If you don't have these documents, be sure to contact your Anthem agent.

This brochure is intended as a brief summary of benefits and services; it is not your Contract/Certificate. If there is any difference between this brochure and your Contract/Certificate, the provisions of the Contract/Certificate will prevail. Benefits and premiums are subject to change.

We want you to be satisfied.

If you aren't satisfied with your coverage, you can cancel it within 30 days after you receive your Contract or Certificate of Coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your Contract or Certificate of Coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

Ready to enroll?

Call your Anthem agent today!

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Anthem. Health. **Join In.**

SmartSense®, Premier, CoreShare,℠ Lumenos® HSA and Blue Access® Value

Disclosure Document

Listed below are specific requirements and procedures for our plans that provide information you need to know when choosing a health care plan as well as after you have coverage. This document is included to help you understand how our SmartSense®, Premier, CoreShare,℠ Lumenos® HSA and Blue Access® Value plans work. This is not your official policy. Please review this Disclosure Document along with the other materials enclosed.

Who Can Apply?

You can apply for coverage for yourself or with your family. You must be a resident of Ohio, under the age of 65, not eligible for Medicare and a legal resident of the U.S. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn 25.

What's A Pre-Existing Condition?

Generally, our policies cover pre-existing conditions after you've been enrolled in the plan for 12 months. A pre-existing condition is any medical or physical condition you had in the six months right before you enrolled. If you received medical advice, a diagnosis, care or treatment for the condition – or if it was recommended that you do so – that qualifies it as "pre-existing".

If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the 12-month waiting period. Anthem Blue Cross and Blue Shield will credit the time you were enrolled on the previous plan.

What Our Individual Health Care Plans Do Not Cover

The following Exclusions and Limitations will help you understand what your health care plan does not include before you enroll. These are just some of the plans' limitations and exclusions. Check your Contract or Certificate of Coverage for a complete listing of benefits, exclusions and maximum payment levels.

Medical Exclusions And Limitations

Our plans do not provide benefits for:

- Services, supplies or charges having to do with pre-existing conditions (see "What's A Pre-Existing Condition?")
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Private duty nursing
- Maternity services, unless an optional maternity rider is purchased
- Experimental or investigative treatment
- Dental and vision, except as spelled out in your Contract
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Benefits covered by Medicare or a governmental program
- Care provided by a member of your family
- Educational services
- Comfort and/or convenience items
- Treatment that's primarily intended to improve your appearance
- Weight loss programs or treatment of obesity
- Hearing aids
- Eyeglasses or contact lenses
- Radial keratotomy or keratomileusis or excimer laser photo
- Sclerotherapy
- Routine foot care
- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Sex transformation surgery
- Custodial care
- Artificial and mechanical hearts
- Workers' compensation
- Specialty drugs purchased at non-network pharmacies
- Over-the-counter drugs, devices or products
- TMJ and Craniomandibular Joint Disorders
- Services we determine aren't medically necessary

In addition our SmartSense, Premier, CoreShare and Lumenos HSA plans also limit the following outpatient services to 20 visits combined network and non-network:

- Speech therapy
- Physical therapy and/or manipulation therapy
- Occupational therapy

Other limitations of our plans include:

- Home health care services limited to 60 visits
- Optional maternity rider subject to a 270-day waiting period (Maternity rider not available on Blue Access Value)
- Pre-existing conditions subject to a 12-month waiting period

Our Appeal Rights And Confidentiality Policy

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within six months of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 30 days of receiving your first appeal. If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board-eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal.

Please call customer service or check your Certificate of Coverage for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to:

Anthem Blue Cross and Blue Shield, Appeals Coordinator
P.O. Box 33200
Louisville, Kentucky 40232-3200

If we uphold our decision throughout the appeals process, you can request a review by the Ohio Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Ohio. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or other family members.

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We Want You To Be Satisfied

If you aren't satisfied with your coverage, you can cancel it within 30 days after you receive your Contract or Certificate of Coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your Contract or Certificate of Coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

If you are approved for coverage, the Contract or Certificate of Coverage you receive will include all the details of your plan. In the event of a conflict between the information in this document and your Contract or Certificate of Coverage, the terms of your Contract or Certificate of Coverage will prevail. Read your Contract or Certificate of Coverage carefully. Anthem has the right to rescind, cancel, terminate or reform your coverage based on provisions described in the Contract or Certificate of Coverage.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Guide, Disclosure Document and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Blue Cross and Blue Shield agent to request them.

Stay focused on your fitness.

YOU'RE ONLY ONE CHECKMARK AWAY

Simply select ACS | Mellon on your application form. We'll take care of setting up your account. We'll also take care of sending you a Welcome Kit to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

Setting up a Health Savings Account

The Lumenos HSA plan is a nice way to save on premiums. But that's just the tip of the savings iceberg. To realize your plan's full financial power, consider opening a health savings account to go with your Lumenos plan. The portability and tax savings of an HSA account can add up fast.

We've joined with Affiliated Computer Services (ACS) and The Bank of New York Mellon (BNY Mellon) to integrate their HSA accounts with our Lumenos HSA plans. Setting up your account with BNY Mellon is easy. Plus, it comes with built-in advantages and conveniences:

- a single customer service contact for the health plan and your HSA
- a single online health site to access your plan benefit information and account details
- several payment and deposit options, including special checks and automatic fund transfers
- competitive interest rates and investment opportunities for the funds in your account

Of course, if you'd rather use another financial institution for your account, that's fine too.

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A closer look

HSA Welcome Kit

If you select ACS | Mellon on your application form, your Health Savings Account will automatically be set up once you're approved for the Lumenos HSA plan, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using your account. A separate application for your account is only required if you choose a financial institution other than BNY Mellon.

This is what the IRS requires if you want to open a Health Savings Account:

- You must be covered by an HSA-compatible high deductible health plan (such as the Lumenos HSA plan)
- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa
- You cannot be covered by any other medical plan that is not an HSA-compatible high deductible health plan
- You cannot be enrolled in Medicare
- You cannot be claimed as a dependent on another individual's tax return
- If you are a veteran, you may not have received veteran's benefits within the last three months
- You cannot be active military

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum of $3,000 in our HSA balance. Investment options include a number of mutual families. Once you're ready to invest, just call the Customer Service number on your Anthem ID card for prospectus with more details.

Debit cards and checkbooks

Use your MasterCard® debit card or your HSA checkbook (provided by BNY Mellon) to pay your health care provider or pharmacy directly for eligible medical expenses, or to get cash from your account.

Deposits to your account

To contribute to your HSA, simply send a check and deposit slip to the address printed on your HSA checkbook. Or you can set up an electronic funds transfer between your bank and BNY Mellon for regular account contributions.

Account activity statements

Each month, you'll receive a statement from BNY Mellon that shows all of your account activity. You'll also receive IRS 1099 and IRS 5498 forms from BNY Mellon near tax time to help with tax preparation.

ACS | Mellon HSA fee and rate schedule

A Deposit Agreement and a Disclosures and Fee Sheet will be in your HSA Welcome Kit. Please refer to those documents for the complete terms and conditions related to your account.

As good as these benefits may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Administrative fees	
One time account set-up	$15
Banking fees	
Monthly account fee	$2.95
Debit card transactions	no charge
Check writing	no charge
ATM transactions	$1
Card replacement	$5
Check reorder	$10
Non-sufficient funds	$25
Stop check service	$25
Duplicate check	$5

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123): Anthem Health Plans of Virginia, Inc. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM and LUMENOS are registered trademarks of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.