



All cost shares shown below are for use of network providers only. Non-network costs are different. Unless otherwise noted, all benefits are subject to calendar year deductible.

Plans-at-a-Glance for Ohio

Plans-at-a-Glance	SmartSense®	Premier	Lumenos® HSA	CoreShare SM	Blue Access® Value
Coinsurance: Individual Calendar Year Deductible	30% Coinsurance: \$500, \$1000, \$1500, \$2500, \$3500, \$5000, \$10000 50% Coinsurance: \$500, \$1000, \$1500, \$2500 (Family: 2 x Individual) How it works: Each family member has an individual deductible. The family deductible can be satisfied by 2 or more members. No one person can contribute more than their individual deductible.	0% Coinsurance: \$2500, \$3500, \$5000, \$10000 20% Coinsurance: \$1500, \$2500 (Family: 2 x Individual) How it works: Each family member has an individual deductible. The family deductible can be satisfied by 2 or more members. No one person can contribute more than their individual deductible.	0% Coinsurance: \$1500, \$2500, \$3000, \$3500, \$5000, \$5500 20% Coinsurance: \$1750; 50% Coinsurance: \$1500 (Family: 2 x Individual) How it works: For family coverage, either one or more members must meet the family deductible before any covered services that are subject to deductible will be paid by the plan.	0% Coinsurance: \$7500, \$10000, \$15000, \$25000 50% Coinsurance: \$750, \$1500, \$2500, \$3500, \$5000 (Family: 2 x Individual) How it works: Each family member has an individual deductible. The family deductible can be satisfied by 2 or more members. No one person can contribute more than their individual deductible.	30% Coinsurance: \$2000, \$3000, \$5000, \$10000 (Family: 2 x Individual) How it works: Each family member has an individual deductible. The family deductible can be satisfied by 2 or more members. No one person can contribute more than their individual deductible.
Coinsurance: Calendar Year Out-of-Pocket Maximum (deductible plus this amount)	30% or 50% Coinsurance: \$3500 (Family: 2 x Individual) How it works: Each family member has an individual out-of-pocket maximum. The family out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual out-of-pocket maximum.	0% Coinsurance: \$0; 20% Coinsurance: \$2500 (Family: 2 x Individual) How it works: Each family member has an individual out-of-pocket maximum. The family out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual out-of-pocket maximum.	0% Coinsurance: \$0; 20% Coinsurance: \$3250; 50% Coinsurance: \$2500 (Family: 2 x Individual) How it works: 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.	0% Coinsurance: \$0; 50% Coinsurance: \$3500 (Family: 2 x Individual) How it works: Each family member has an individual out-of-pocket maximum. The family out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual out-of-pocket maximum.	30% Coinsurance: \$3000 (Family: 2 x Individual) How it works: Each family member has an individual out-of-pocket maximum. The family out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual out-of-pocket maximum.
Plan Lifetime Maximum	\$7 million per member, network and non-network services combined	\$7 million per member, network and non-network services combined	\$7 million per member, network and non-network services combined	\$2 million per member, network and non-network services combined	\$7 million per member, network and non-network services combined
Doctors' Office Visits	Office Visit Copayment - first 3 visits: \$35 Copayment , deductible waived, for first 3 visits per member per calendar year for PCP/specialist. Office Visit - 4+ visits are subject to deductible and coinsurance Other Services: 30% or 50% Coinsurance¹	Office Visit Copayment (deductible waived): \$30 Copayment for PCP; \$40 Copayment for specialist No-Office-Visit-Copayment Option (available on \$1500/20% and \$2500/0% plans): 0% or 20% Coinsurance¹ Other Services: 0% or 20% Coinsurance¹	0%, 20 or 50% Coinsurance¹	0% or 50% Coinsurance¹	Office Visit Copayment - first 2 visits only: \$30 Copayment , visits 3+ are not covered Other Covered Services: 30% Coinsurance
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Professional & Diagnostic (X-ray, lab, anesthesia, surgeon, etc.)	30% or 50% Coinsurance¹	0% or 20% Coinsurance¹	0%, 20% or 50% Coinsurance¹	0% or 50% Coinsurance¹	30% Coinsurance (deductible waived)
Inpatient Services (overnight hospital/facility stays)	30% or 50% Coinsurance¹	0% or 20% Coinsurance¹	0%, 20% or 50% Coinsurance¹	0% or 50% Coinsurance¹ \$750 Facility Copayment applies on 50% Coinsurance plans	30% Coinsurance
Outpatient Services (without overnight hospital/facility stays)	30% or 50% Coinsurance¹	0% or 20% Coinsurance¹	0%, 20% or 50% Coinsurance¹	0% or 50% Coinsurance¹ \$200 Facility Copayment applies on 50% Coinsurance plans	30% Coinsurance
Emergency Room Services	30% or 50% Coinsurance¹	0% or 20% Coinsurance¹	0%, 20% or 50% Coinsurance¹	0% or 50% Coinsurance¹	30% Coinsurance (plus \$60 Copayment if not admitted)
Preventive Care Services	30% or 50% Coinsurance¹ For mammography, Pap test, well-child and immunization services only. 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.	Preventive Office Visits (deductible waived): \$30 Copayment for PCP; \$40 Copayment for specialist No-Office-Visit-Copayment Option (available on \$1500/20% and \$2500/0% plans): 20% Coinsurance on Preventive Services, deductible waived. Other Preventive Services: 20% Coinsurance , deductible waived. Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more.	0%, 20% or 50% Coinsurance¹ (deductible waived with 0% Coinsurance: \$1500, \$3000 and \$5000 deductible plans) Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more. 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 to 9 (network and non-network combined). This limit applies to 0% Coinsurance: \$2500, \$3500, \$5500 deductible plans and 20% Coinsurance: \$1750 deductible plans only.	0% or 50% Coinsurance¹ Includes Lab/X-ray for routine Pap tests, annual mammograms, colorectal cancer screenings or PSA screenings ONLY. Other preventive tests are not covered. Well-child care: (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.	30% Coinsurance Includes Lab/X-ray for routine Pap tests, annual mammograms, colorectal cancer screenings or PSA screenings ONLY. Other preventive tests are not covered. Well-child care: 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.
Maternity	Not Covered	Not Covered (see Optional Coverage below)	Not Covered (see Optional Coverage below)	Not Covered	Not Covered
Optional Coverage (at additional cost)	Dental, Life	Dental, Life, Maternity (optional maternity rider available for purchase with \$2500 individual/\$5000 family or greater deductible; subject to 270-day waiting period)	Dental, Life, Maternity (optional maternity rider available for purchase with \$2500 or greater deductible; subject to 270-day waiting period)	Dental, Life	Dental, Life

Prescription Drugs	SmartSense®	Premier	Lumenos® HSA	CoreShare SM	Blue Access® Value
Retail Drugs (and Mail Order Drugs when available)	STANDARD DRUG COVERAGE 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.	STANDARD DRUG COVERAGE Separate \$250 per member deductible for Tiers 2, 3 and 4. Tier 1 Drugs (Generic required if available): Retail (30 day supply): \$15 Copayment ; Mail Order (90 day supply): \$30 Copayment Tiers 2, 3 and 4: Greater of \$30 Copayment or 40% Coinsurance for either Retail or Mail Order Tiers 2, 3 and 4: \$4000 annual Prescription Drug out-of-pocket maximum per member.	0%, 20% or 50% Coinsurance¹	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.	Maximum Annual Benefit is \$500 per person. Separate \$200 per member deductible for Brand name drugs on formulary. Generic Drugs on Formulary: Retail (30 day supply) \$10 Copayment ; Brand name Drugs on Formulary: 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
Optional Drug Coverage (when available)	UPGRADE DRUG COVERAGE Separate \$250 per member deductible for Tiers 2, 3 and 4. Tier 1 Drugs (Generic required if available): Retail (30 day supply): \$15 Copayment ; Mail Order (90 day supply): \$30 Copayment Tiers 2, 3 and 4: Greater of \$30 Copayment or 40% Coinsurance for either Retail or Mail Order Tiers 2, 3 and 4: \$4000 annual Prescription Drug out-of-pocket maximum per member.	UPGRADE DRUG COVERAGE Retail Drugs (30 day supply): Tier 1 (\$15 Copayment)/Tier 2 (\$30 Copayment)/Tier 3 (\$60 Copayment)/Tier 4 (25% Coinsurance); separate \$2500 out-of-pocket maximum for Tier 4) Mail Order Drugs (90 day supply): Tier 1 (\$30 Copayment)/Tier 2 (\$75 Copayment)/Tier 3 (\$150 Copayment)/Tier 4 (25% Coinsurance); separate \$2500 out-of-pocket maximum for Tier 4)	Not Available	Not Available	Not Available

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Other Benefits	SmartSense	Premier	Lumenos HSA	CoreShare	Blue Access Value
Durable Medical Equipment	\$4000 per calendar year maximum for DME or Orthotics; Separate \$4000 per calendar year maximum for Prosthetics (network and non-network combined).				
Home Health Care	60 visit limit				
Hospice Care	Coverage if member diagnosed as terminal with life expectance of 6 months or less and elects to receive palliative rather than curative care.				
Mental Health	Biologically based Mental Illnesses are covered the same as any other illness and limits do not apply. Non-Biologically based inpatient mental health services Benefit period maximum - 10 days per benefit period (network and non-network combined)				
Alcoholism/Substance Abuse	Inpatient substance abuse services benefit period maximum - 10 days per benefit period (network and non-network combined). Inpatient and outpatient substance abuse rehab programs limited to 2 per lifetime. \$550 benefit period combined maximum for non-network inpatient and outpatient substance abuse.				
Organ/Tissue Transplant	Covered under same lifetime maximum as plan benefit.				
Skilled Nursing Care	90 day limit				
Speech Therapy	20 visits per calendar year (not available with Blue Access Value)				
Physical Therapy/ Spinal Manipulation	20 visit limit per calendar year, combined (not available with Blue Access Value)				
Occupational Therapy	20 visits per calendar year (not available with Blue Access Value)				
Pre-existing Waiting Period	12 months; If coverage applied for within 63 days of terminating membership with another "creditable" health care plan, then prior coverage can be used for credit toward the 12-month waiting period.				
Typical Customer Profile²	Individuals and Families looking for strong protection and more affordable options. Individual contractors, Self Employed, Dependents, and Students. Early Retirees.	Individuals and Families looking for broader benefits. Families with young children, or planning to have young children. Early Retirees.	Individuals, Families, Professionals, Tax savvy and financially conscious.	Uninsured; Individuals willing to accept a higher-cost share for a lower premium. Rarely visits doctor or fills a prescription.	Uninsured; Individuals looking for affordable options. Rarely visits doctor. Limited prescription brand coverage use.

¹ Coinsurance is designated by the plan you choose.
² The typical customer profile is only a guideline of types of customers who typically purchase these products. Products and plans are open and utilized by all customer types.

This Plans-at-a-Glance is a brief outline of the benefits available in the plans above and is intended as a high level, quick reference guide for agent use ONLY. In addition, this Plans-at-a-Glance is NOT to be shared with consumers for the purpose of prospecting or as pre-sale collateral. Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Life and Disability products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark 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.