



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

Coinsurance: Individual Calendar Year Deductible

Premier Plus

0% Coinsurance: \$2500, \$3500, \$5000, \$10000
20% 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.

Coinsurance: Calendar Year Out-of-Pocket Maximum (deductible plus this amount)

0% Coinsurance: \$0
20% 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

None

Doctors' Office Visits

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**

SmartSense[®] Plus

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.

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.

None

Office Visit Copayment - first 3 visits: **\$35 Copayment**, deductible waived, for first 3 visits per member per calendar year for PCP/specialist. Other office services are subject to deductible and coinsurance.
Office Visit - 4+ visits are subject to deductible and coinsurance
Other Services: **30% or 50% Coinsurance¹**

CoreShareSM

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.

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.

None

0% or 50% Coinsurance¹

Lumenos[®] HSA Plus

0% Coinsurance: \$1500, \$2500, \$3500, \$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: \$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.

None

0%, 20% or 50% Coinsurance¹

NOT FOR PROMOTIONAL USE · FOR AUTHORIZED ANTHEM AGENTS ONLY · NOT FOR PROMOTIONAL USE · FOR AUTHORIZED ANTHEM AGENTS ONLY · NOT FOR PROMOTIONAL USE · FOR AUTHORIZED ANTHEM AGENTS ONLY

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

0% or 20% Coinsurance¹

30% or 50% Coinsurance¹

0% or 50% Coinsurance¹

0%, 20% or 50% Coinsurance¹

Inpatient Services (overnight hospital/facility stays)

0% or 20% Coinsurance¹

30% or 50% Coinsurance¹

0% or 50% Coinsurance¹
\$750 Facility Copayment per admission applies on 50% Coinsurance plans

0%, 20% or 50% Coinsurance¹

Outpatient Services (without overnight hospital/facility stays)

0% or 20% Coinsurance¹

30% or 50% Coinsurance¹

0% or 50% Coinsurance¹
\$200 Facility Copayment applies on 50% Coinsurance plans for outpatient surgeries performed at medical facilities

0%, 20% or 50% Coinsurance¹

Emergency Room Services

0% or 20% Coinsurance¹

30% or 50% Coinsurance¹

0% or 50% Coinsurance¹

0%, 20% or 50% Coinsurance¹

Preventive Care Services Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more.

0% Coinsurance, not subject to deductible

0% Coinsurance, not subject to deductible

0% Coinsurance, not subject to deductible

0% Coinsurance, not subject to deductible

Maternity

Not Covered (see Optional Coverage below)

Not Covered

Not Covered

Not Covered

Optional Coverage (at additional cost)

Dental, Life, Maternity (optional maternity rider available for purchase with \$2500 individual/\$5000 family or greater deductible; subject to 270 day waiting period and \$3000 professional services/delivery copayment)

Dental, Life

Dental, Life

Dental, Life

Prescription Drugs	Premier Plus	SmartSense® Plus	CoreShare SM	Lumenos® HSA Plus
Retail Drugs (and Mail Order Drugs when available)	<p>STANDARD DRUG COVERAGE</p> <p>Separate \$250 per member deductible for Tiers 2, 3 and 4. Member is responsible for the difference in allowable charge between brand and generic, plus copayment or coinsurance.</p> <p>Tier 1 Drugs: \$15 Copayment; Mail Order (90 day supply): \$30 Copayment</p> <p>Tiers 2, 3, and 4): Greater of \$30 Copayment or 40% Coinsurance for either Retail or Mail Order.</p> <p>Tiers 2, 3, and 4: \$4000 annual Prescription Drug out-of-pocket maximum per member.</p>	<p>STANDARD DRUG COVERAGE</p> <p>For Drugs on Formulary: Greater of \$15 Copayment or 40% Coinsurance</p> <p>For Drugs not on Formulary: Member is responsible for entire cost after applied Anthem negotiated discount.</p>	<p>For Drugs on Formulary: Greater of \$15 Copayment or 40% Coinsurance</p> <p>For Drugs not on Formulary: Member is responsible for entire cost after applied Anthem negotiated discount.</p>	<p>0%, 20% or 50% Coinsurance¹</p>
Optional Drug Coverage (when available)	<p>UPGRADE DRUG COVERAGE</p> <p>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)</p> <p>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).</p>	<p>UPGRADE DRUG COVERAGE</p> <p>Separate \$250 per member deductible for Tiers 2, 3 and 4. Member is responsible for the difference in allowable charge between brand and generic, plus copayment or coinsurance.</p> <p>Tier 1 Drugs Generic required if available): Retail (30 day supply): \$15 Copayment; Mail Order (90 day supply): \$30 Copayment</p> <p>Tiers 2, 3, and 4: Greater of \$30 Copayment or 40% Coinsurance for either Retail or Mail Order.</p> <p>Tiers 2, 3, and 4: \$4000 annual Prescription Drug out-of-pocket maximum per member.</p>	Not Available	Not Available

NOT FOR PROMOTIONAL USE · FOR AUTHORIZED ANTHEM AGENTS ONLY · NOT FOR PROMOTIONAL USE · FOR AUTHORIZED ANTHEM AGENTS ONLY · NOT FOR PROMOTIONAL USE · FOR AUTHORIZED ANTHEM AGENTS ONLY

Other Benefits	Premier Plus	SmartSense Plus	CoreShare	Lumenos HSA Plus
Home Health Care	60 visits per calendar year			
Hospice Care	Coverage if member diagnosed as terminal with life expectancy of 6 month 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 - 5 days per benefit period (network and non-network combined)			
Alcoholism/Substance Abuse	Inpatient substance abuse services benefit period maximum - 5 days per benefit period (network and non-network combined).			
Skilled Nursing Care	90 day limit per calendar year			
Speech Therapy	20 visits per calendar year			
Physical Therapy/ Spinal Manipulation	20 visit limit per calendar year, combined			
Occupational Therapy	20 visits per calendar year			
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 Profile ²	Individuals and Families looking for broader benefits. Families with young children, or planning to have young children. Early Retirees.	Individuals and Families looking for strong protection and more affordable options. Individual contractors, Self Employed, Dependents, and Students. Early Retirees.	Uninsured; Individuals willing to accept a higher-cost share for a lower premium. Rarely visits doctor or fills a prescription.	Individuals, Families, Professionals, Tax savvy and financially conscious.

¹ Coinsurance is designated by the plan chosen.

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.