Ohio Open Enrollment Options

Anthem BlueCross BlueShield

Basic Comprehensive Major Medical (CMM) and Standard Comprehensive Major Medical (CMM) Plans

Benefits	Basic CMM	Standard CMM
Benefit Period	**Calendar Year**	**Calendar Year**
Dependent Age	To age 28	To age 28
Out-of-Pocket Limit for Coinsurance **There is no family out-of-pocket limit for coinsurance; each covered person must meet his/her own out-of-pocket maximum.**	∘ $5,000 per covered individual (does not include deductible)	∘ $5,000 per covered individual (does not include deductible)
Lifetime Maximum	None	None
Deductible **There is no family deductible; each covered person must meet his/her own deductible.**	∘ $1,000 per covered individual	∘ $750 per covered individual
Coinsurance	50% coinsurance for all covered services listed unless indicated otherwise, none after the out-of-pocket limit is reached.	30% coinsurance for all covered services listed unless indicated otherwise, none after the out-of-pocket limit is reached.
Deductible/Copayment	Deductible applies to all services. Emergency room care requires an additional copayment[1] of $75 per visit, which is waived if admitted to the hospital.	Deductible applies to all services. Emergency room care requires an additional copayment[1] of $75 per visit, which is waived if admitted to the hospital.
Pre-existing Period	None for Federally Eligible Individuals (FEIs). If you are not a Federally Eligible Individual (non-FEI), there is a 12-month pre-existing condition waiting period. See the definition of FEI and non-FEI further on in this brochure.	None for Federally Eligible Individuals (FEIs). If you are not a Federally Eligible Individual (non-FEI), there is a 12-month pre-existing condition waiting period. See the definition of FEI and non-FEI further on in this brochure.
Physician Office Visit/Services	50% coinsurance after deductible	30% coinsurance after deductible
Inpatient Facility/Services	50% coinsurance after deductible	30% coinsurance after deductible
Maternity Services	Not covered, except for complications of pregnancy.	Payable for all covered services (after 270 day waiting period for non-FEIs). Maternity and routine nursery care benefits for normal delivery limited to $3,000 per occurrence.
Prescription Drugs	Generic drugs: $15 copay Brand drugs costing less than $75: $15 copay Brand drugs costing more than $75: 20% coinsurance NOTE: Brand-name drugs are not covered if a generic equivalent exists.	Generic drugs: $15 copay Brand drugs costing less than $75: $15 copay Brand drugs costing more than $75: 20% coinsurance NOTE: Brand-name drugs are not covered if a generic equivalent exists.
Preventive Care Services **Includes preventive services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.**	Eligible services are covered without any copayment, coinsurance, or deductible.	Eligible services are covered without any copayment, coinsurance, or deductible.

[1] **Copayment does not apply to deductible or out-of-pocket limit**

Application Process: You can apply for our coverage by completing an Ohio Open Enrollment Options Application. If you need assistance, contact your agent or call the toll-free customer service number and an agent will assist you. Please complete the application in its entirety and be sure to include all appropriate signatures.

Completed applications should be mailed to:

Anthem Blue Cross and Blue Shield
P.O. Box 659806
San Antonio, TX 78265-9106

You will receive a letter advising of the approval or denial of your application. If approved, your identification card and information on how to obtain your Policy will be sent in a separate mailing.

Payment can be submitted with the application by check, automatic bank draft or credit card. No payments will be processed until your application has been approved for coverage.

If you do not submit payment with the application or apply for automatic bank draft, you will receive a bill in the mail.

- If you are an FEI, your bill will be mailed immediately upon enrollment. The first payment will be due by your effective date.
- If you are a non-FEI member, there is a 90-day waiting period prior to your effective date. Your bill will be mailed approximately 20 days prior to your effective date and will be due on your effective date.

Payment can be made by check or calling customer service to make a one-time payment by phone. Automatic bank draft payments can be set up at enrollment or by contacting customer service after you are enrolled.

OHBR15002CMM Rev. 5/12

Rules and Requirements

Notice

Once this coverage is effective, if you or your family members become covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time.

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 or any other coverage 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 28.

What is a Federally Eligible Individual

Ohio law requires us to accept a certain number of individuals for open enrollment coverage without regard to health status. If you qualify as a Federally Eligible Individual (FEI), your coverage will be effective immediately without any pre-existing condition exclusion period. If you do not qualify as a FEI, you may apply as a non-FEI for open enrollment coverage.

You are a **Federally Eligible Individual** if you are an Ohio resident and meet all of the following conditions:

1. You had health coverage for at least 18 months without a break in coverage greater than 63 days.
2. Your most recent health coverage was under a group health plan, governmental plan or church plan.
3. You are not eligible for coverage under any of the following plans:
   a. A group health plan
   b. Medicare
   c. Medicaid
4. You do not have any other health coverage.
5. Your most recent health coverage was not terminated because of nonpayment of premiums or fraud.
6. If you had been offered the option to continue coverage under COBRA or a state continuation plan, you both elected and exhausted the continuation coverage.

If we have not yet met our enrollment quota, we will offer you the Ohio health care CMM Basic or Standard benefit plans for purchase. You may need to submit proof of previous creditable coverage.

You are a **non-Federally Eligible Individual** if you are an Ohio resident and meet the following conditions:

1. You are not applying for coverage as an employee of an employer, member of an association or member of any other group.
2. You do not have any other health coverage and are not eligible to be covered under any private or public health benefit plans including the following:
   a. Medicare or Medicare supplement policy
   b. Medicaid
   c. Any COBRA or state continuation coverage plan
   d. Other health benefits arrangement

If we have not met our enrollment quota, we will offer you the Ohio health care CMM Basic or Standard benefit plans for purchase. We are not required to accept applicants who at the time of enrollment, are confined to a health care facility due to chronic illness or permanent injury.

Please note, as a non-FEI member age nineteen (19) and older, coverage will be limited by a pre-existing conditions waiting period for the first 12 months, and you will have a 90-day waiting period between the date we receive your completed application and the effective date of your coverage. The pre-existing waiting period does not apply to individuals under the age of 19.

In addition, there is a 270-day waiting period for maternity on the Standard Plan.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review / Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

Non-covered services

The following are not covered:

- Dental treatment
- Eyeglasses, contact lenses and hearing aids
- Experimental investigational or unproven procedures, treatment or devices
- Non-medically necessary services, supplies or charges
- Cosmetic treatment for weight loss or obesity
- Custodial care, rest cures, private duty nursing
- Foot care for comfort or appearance
- Sterilization reversal
- Transsexual surgery
- Physical therapy and rehabilitation provided by immediate family
- Voluntary abortions
- Non-medically necessary infertility services including invitro fertilization, artificial insemination, GIFT and ZIFT

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 Policy 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 105557
Atlanta, GA 30348-5557

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.

We want you to be satisfied

If you aren't satisfied with your medical coverage, you can cancel it within 30 days after you receive your Policy 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 Policy online or receive a paper copy of it upon request as outlined in your initial membership letter.

This document is not a part of the Policy. If you are approved for coverage, the Policy you receive will include all the details of your plan. In the event of a conflict between the information in this document and your Policy, the terms of your Policy will prevail. Read your Policy carefully. Anthem has the right to rescind, cancel, terminate or reform your coverage based on provisions described in the Policy

After 9/23/12, to view a Summary of Benefits and Coverage please visit www.healthcare.gov

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee 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.