Anthem®

Health. **Join In.**

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

Our plans fit your plans

Lumenos® HSA
CoreShare℠
Blue Access® Value

INBR0015598BCL (2/10)

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 Indiana for over 65 years. We're committed to helping simplify your life and improving your health. In addition, we offer:

- One of the largest provider networks in Indiana. With more than 41,000 doctors and specialists and over 150 hospitals throughout Indiana, 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 doctors and specialists and over 150 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 coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the costs, 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 plans 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.

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 (amounts shown do not include deductible)	**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	$0	$0	$0	$0
Family — NON-NETWORK:	$3,000 or $13,000	$16,500	$5,000	$6,000	$7,000	$10,000	$11,000
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:** 70%, 40% or 40% Coinsurance[1]						
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** 50%, 20% or 0% Coinsurance[1] **NON-NETWORK:** 70%, 40% or 40% Coinsurance[1]						
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** 50%, 20% or 0% Coinsurance[1] **NON-NETWORK:** 70%, 40% or 40% Coinsurance[1]						
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** 50%, 20% or 0% Coinsurance[1] **NON-NETWORK:** 70%, 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% options) **NON-NETWORK:** 70%, 40% or 40% Coinsurance[1]						
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 12-month waiting period)						
Prescription Drug Coverage	**Lumenos HSA**						
Retail Drugs (and Mail Order Drugs when available)	**NETWORK:** 50%, 20% or 0% Coinsurance[1] **NON-NETWORK:** 70%, 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						

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

NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.

CoreShare℠ Is this the right plan for you?

CoreShare offers a simple plan design and is also one of our lowest cost options. 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 plans 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 a 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.

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.

Benefits	CoreShare℠								
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 (amounts shown do not include deductible)	**Add Your Chosen Deductible to the Amount Below**								
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:** **70% or 30% Coinsurance**[1]
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** **50% or 0% Coinsurance**[1] **NON-NETWORK:** **70% 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:** **70% 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:** **70% 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	Not Covered
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life

Prescription Drug Coverage	CoreShare
Retail Drugs (and Mail Order Drugs when available)	**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:** · **For Drugs on Formulary:** Greater of **$15 Copayment or 40% Coinsurance;** Member is also responsible for difference between Anthem allowable charge and actual cost of drug. ·**For Drugs Not on Formulary:** 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, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Therapy Services, 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 toward the deductible or out-of-pocket maximum. Facility Copayment is still required even if out-of-pocket maximum has been met.

NOTE: 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 $30 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.

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
Individual — NON-NETWORK:	$4,000	$6,000	$10,000	$20,000
Family — NETWORK:	$4,000	$6,000	$10,000	$20,000
Family — 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
Individual — NON-NETWORK:	$6,000	$6,000	$6,000	$6,000
Family — NETWORK:	$6,000	$6,000	$6,000	$6,000
Family — 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:** **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 limit per member per year for diagnostic services, 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** **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:** **40% Coinsurance** (plus **$60 Copayment** if not admitted)			
Preventive Care Services	Includes Lab/X-ray for routine Pap tests, annual mammograms, colorectal cancer screenings or PSA screenings ONLY. Other preventive tests are not covered. **NETWORK:** **30% Coinsurance** **NON-NETWORK:** **40% Coinsurance** **WELL-CHILD CARE:** **Network or Non-network** Not covered			
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 on Formulary:** Retail (30 day supply) **$10 Copayment**; Mail order (90 day supply) **$20 Copayment** **Brand on Formulary:** Retail (30 day supply) **$25 Copayment**; Mail order (90 day supply) **$50 Copayment** **Generic Non-Formulary:** Retail (30 day supply) **$10 Copayment**; Mail order (90 day supply) **$20 Copayment** **Brand 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, Durable Medical Equipment, Home Health Care, Hospice Care, Mental Health, Organ Transplants, Skilled Nursing Care, Substance Abuse, Therapy Services, 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

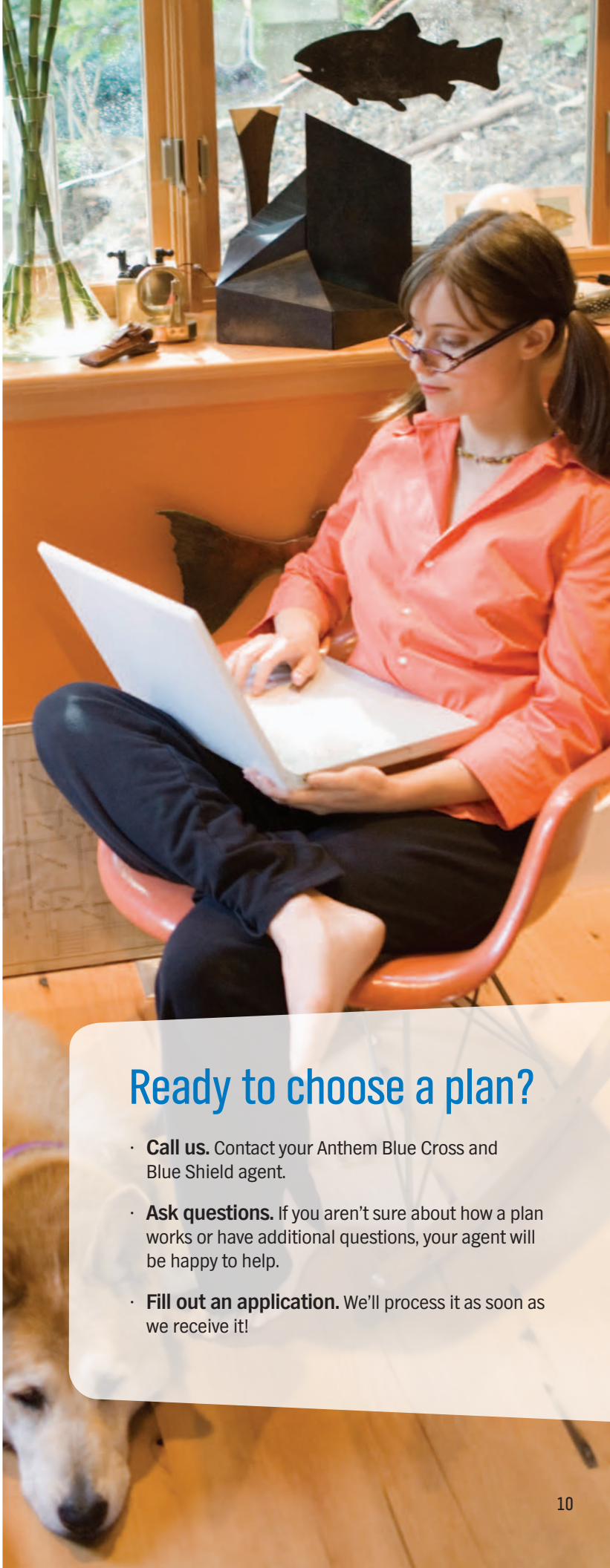
You can add Anthem Blue Preferred® Term Life Insurance to your health coverage. It's easy. There are no medical exams or extra forms to fill out. Simply use your application to apply for coverage.

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!

Anthem
Health. **Join In.**

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

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 additional information about this coverage please see the Coverage Details. This document should be included with your information kit, or if you have printed this brochure from your computer, it should be at the end. If you did not receive a copy of the Coverage Details, 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 of Coverage. If there is any difference between this brochure and your Certificate of Coverage, the provisions of the Certificate of Coverage 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!

Coverage Details Things you need to know before you buy...

Anthem Health. Join In.

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

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 important information 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 Indiana, 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.

The following children are eligible for coverage, regardless of the level of support by the Subscriber: The Subscriber's natural children, newborn and legally adopted children, or children who we have determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

For the following dependent children to be eligible for coverage, the Subscriber must provide at least 50% of their support: Stepchildren, children for whom the Subscriber or the Subscriber's spouse is a legal guardian, or the Subscriber's or the Subscriber's spouse's grandchildren or other blood relatives.

What's A Pre-Existing Condition?

Generally, our plans 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 12 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.

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 Contract or 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 Indiana Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Indiana. 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 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.

Anthem
Health. **Join In.**

This document is not a part of the Contract or Certificate of Coverage. 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, Coverage Details 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.