

SmartSense Plan Coverage

OPTION: 30% Coinsurance

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

PLAN LIFETIME MAXIMUM

Network							Non-Network						
YOU PAY 30% Coinsurance							YOU PAY 50% Coinsurance						
Individual:	\$500	\$1,000	\$1,500	\$2,500	\$5,000	\$10,000	Individual:	\$500	\$1,000	\$1,500	\$2,500	\$5,000	\$10,000
	\$4,000	\$4,500	\$5,000	\$6,000	\$8,500	\$13,500		\$8,000	\$8,500	\$9,000	\$10,000	\$12,500	\$17,500
Family:	\$1,000	\$2,000	\$3,000	\$5,000	\$10,000	\$20,000	Family:	\$1,000	\$2,000	\$3,000	\$5,000	\$10,000	\$20,000
	\$8,000	\$9,000	\$10,000	\$12,000	\$17,000	\$27,000		\$16,000	\$17,000	\$18,000	\$20,000	\$25,000	\$35,000
\$7,000,000 per member for network and non-network services combined													

SmartSense Plan Benefits¹

DOCTORS' OFFICE VISITS

PREVENTIVE CARE SERVICES

(includes well-child care, immunizations, PSA screening, Pap smears, mammograms, colorectal cancer exams, colonoscopy, sigmoidoscopy. Preventive office visits including well child visits are covered under the Doctors' Office Visit benefit. Child immunizations are covered at 100% both network and non-network from birth through age 5)

DIAGNOSTIC SERVICES

HOSPITAL (inpatient & outpatient), **OUTPATIENT SURGERY**

EMERGENCY ROOM SERVICES

MATERNITY

DENTAL

LIFE

Network		Non-Network	
YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED		YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED	
OFFICE VISIT COPAY: \$35 Copay for the first 3 visits per person per calendar year for primary care physician/specialist (deductible waived); then 30% Coinsurance for 4+ office visit charges		50% Coinsurance	
OTHER SERVICES: 30% Coinsurance			
30% Coinsurance		50% Coinsurance	
30% Coinsurance		50% Coinsurance	
Not covered		30% Coinsurance	
		Not covered	
Coverage available at additional cost		Coverage available at additional cost	

SmartSense Drug Coverage

SMARTSENSE INCLUDES DRUG COVERAGE

GENERIC ON FORMULARY LIST, PLUS LIMITED NUMBER OF BRAND-NAME DRUGS

SMARTSENSE DRUG OPTIONAL UPGRADE

WHEN YOU PURCHASE TIER 1 DRUGS (generic required if available)

PURCHASE OF BRAND AND/OR SPECIALTY DRUGS (tiers 2, 3, and 4)

In network subject to a separate deductible and out-of-pocket limit. Note: Specialty injectable drugs only available through Anthem's Specialty Rx network and are not covered out-of-network.

Network		Non-Network	
YOU PAY		YOU PAY	
DRUGS ON FORMULARY: Greater of \$15 copay or 40% Coinsurance	FOR DRUGS NOT ON FORMULARY: Member is responsible for entire cost after applied Anthem negotiated discount	FOR DRUGS ON FORMULARY: Greater of \$15 copay or 40% Coinsurance. Member is responsible for difference between Anthem allowable charge and actual cost of drug	FOR DRUGS NOT ON FORMULARY: Member is responsible for entire cost.
YOU PAY		YOU PAY	
30 day supply: \$15 copay; 90 day mail order supply: \$30 copay			
Separate \$250 per person deductible for Brand & Specialty drugs. Greater of \$30 copay or 40% coinsurance up to \$4,000 max out-of-pocket. Member is responsible for difference in allowable charge between brand and generic, plus copayment or coinsurance.		50% coinsurance (minimum \$60) per prescription Note: Specialty injectable drugs only available through Anthem's Specialty Rx network and are not covered out-of-network.	

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
- Speech Therapy
- Therapy Services
- Urgent Care

¹UNLESS OTHERWISE NOTED, ALL BENEFITS ARE SUBJECT TO THE CALENDAR YEAR DEDUCTIBLE.

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 or certificate of coverage. In the event of a conflict between the contract or certificate of coverage and this SmartSense Benefit Guide, the terms of the contract or certificate of coverage will prevail.

Understanding SmartSense[®] Coverage

Is your doctor or dentist in
one of our networks?

[Go to anthem.com](https://www.anthem.com) > [Find a Doctor](#)

Some definitions

So we're all on the same page

Deductible: The amount of out-of-pocket expenses you have to pay each year before your health plan kicks in and starts paying for services. Network and non-network deductibles are separate and do not accumulate towards each other.

Coinsurance: The percentage of money you have to pay out of your own pocket for covered services. It's the portion of the bill not paid by your health plan after your deductible has been reached.

Copay (copayment): A specific dollar amount you have to pay out of your own pocket for covered services.

Out-of-pocket limit: The total amount of money (not counting your premiums) you have to pay each year for your health care coverage. Your deductible and coinsurance payments for covered services count toward your out-of-pocket limit. Network and non-network out-of-pocket limits are separate and do not accumulate towards each other.

Premium: The amount you pay on a regular basis to keep your health plan active. (Your premiums do not count toward your annual deductible.)

Covered service: This refers to the health care services that are covered by your health plan.

Brand-name drugs: Drugs that are manufactured and marketed under a registered trade name.

Generic drugs: Have the same active ingredients as their brand-name equivalent and provide the same clinical benefits.

Specialty drugs: High cost, scientifically engineered drugs that are usually injected or infused.

About our network providers

Notice of provider arrangements

Your network provider's agreement for providing covered services may include financial incentives or risk-sharing relationships based on utilization and quality of services. If you have any questions, please contact Anthem or your provider.

To help you avoid unnecessary out-of-pocket expenses

For some services or supplies (such as prescription drugs), your doctor must receive authorization from Anthem that defines and/or limits the conditions under which the service or supply will be covered. For other services (such as organ transplants), your doctor must certify (and Anthem must approve) that the service is medically necessary and takes place in the appropriate setting. Neither process is a guarantee of coverage.

Using non-network providers

If you receive covered services from a non-network provider, you are responsible for the difference between the actual charge billed for covered services and the maximum allowable amount your plan covers plus any deductible, copayments, coinsurance and charges that are not covered.

Networks available:

- PPO network
- Choice network

Prescription coverage

The cost of prescription drugs can be staggering. In fact, prescription drug costs are one of the leading drivers of rising health care costs. Helping control those costs is key to providing affordable health care and health insurance to everyone.

Anthem has a formulary – or special list of prescription drugs that our health plans cover. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medications from this list.

For more complete coverage

Dental and Term Life Insurance

You can combine this health plan with Dental Blue[®] and/or Blue Preferred[®] Term Life Insurance. Combining coverage is not only easy, it can save you money, too. And you'll only have to deal with one application, one bill and one monthly premium.



SmartSense[®]

Benefit Guide for Missouri

Who can apply?

You can apply for SmartSense coverage for yourself or with your family. You must be under the age of 65, reside in the Missouri service area, be a legal resident of the U.S. and not currently pregnant. 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 preexisting condition?

Generally, SmartSense covers preexisting conditions after you've been enrolled in the plan for 12 months. A preexisting condition is any condition that was diagnosed, treated, or produced symptoms within the 12 months right before you enrolled that would have caused an ordinarily prudent person to seek medical diagnosis or treatment.

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 we do not cover.

SmartSense plans don't provide benefits for services, supplies or charges having to do with preexisting conditions (see "What's a preexisting condition?"); private duty nursing; maternity services; 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); care provided by a member of your family; 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; artificial insemination, fertilization, infertility drugs or sterilization reversal; sex transformation surgery; custodial care; artificial and mechanical hearts; workers' compensation; TMJ and Craniomandibular

Joint Disorders and services we determine aren't medically necessary.

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

These are just some of SmartSense plans' limitations and exclusions. Check your contract

or certificate of coverage for a complete listing of benefits, exclusions and maximum payment levels. We want you to be satisfied.

If you aren't satisfied with your SmartSense 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.

This brochure is only a summary of SmartSense benefits and 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 brochure 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.

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name for 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. Independent licensees of the Blue Cross and Blue Shield Association. Life and disability products are underwritten by Anthem Life Insurance Company. © 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