OHIO COUNTY FISCAL COURT

Health Insurance Benefits Package
Effective July 1, 2021 thru June 30, 2021

Ohio County Fiscal Court
2021 Health Plan Comparison
BASIC PLAN

	CURRENT PLAN	NEW PLAN
	2020	2021
	Core Plan	Basic Plan
	HSAPE06	HSAPE13T5
	IN-NETWORK SUMMARY OF BENEFITS	
Lifetime Max	Unlimited	Unlimited
HRA Dollars	$500	$2,000
Deductible (Individual/Family)	$3000/$6000	$6150/$12300
Out of Pocket Max (Individual/Family)	$5000/$10000	$6450/$12900
Coinsurance	Anthem Pays 80% after Deductible	Anthem Pays 100% after Deductible
Inpatient Services	Anthem Pays 80% after Deductible	Anthem Pays 100% after Deductible
Outpatient Surgery	Anthem Pays 80% after Deductible	Anthem Pays 100% after Deductible
ER Services	Anthem Pays 80% after Deductible	Anthem Pays 100% after Deductible
PCP Visit	Anthem Pays 80% after Deductible	Anthem Pays 100% after Deductible
Specialist	Anthem Pays 80% after Deductible	Anthem Pays 100% after Deductible
Preventative	Paid 100%	100%
Retail Drugs 30 Day Supply	Anthem Pays 80% after Deductible	Level 1 $10/$35/$75 Level 2 $20/$45/$85

Your summary of benefits

Anthem

BASIC PLAN

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA Option E13 with Rx Option T5

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$6,150 person / $12,300 family	$18,450 person / $36,900 family
Out-of-Pocket Limit	$6,450 person / $12,900 family	$19,350 person / $38,700 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prenatal and Post-natal Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility Visit:		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	0% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *Rx Choice Tiered Network w/R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*			
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$10 copay per prescription after deductible is met (retail) and $25 copay per prescription after deductible is met (home delivery)	$20 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$35 copay per prescription after deductible is met (retail) and $105 copay per prescription after deductible is met (home delivery)	$45 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$75 copay per prescription after deductible is met (retail) and $225 copay per prescription after deductible is met (home delivery)	$85 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	25% coinsurance up to $350 per prescription after deductible is met (retail and home delivery)	25% coinsurance up to $450 per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Ohio County Fiscal Court
2021 Health Plan Comparison
ENHANCED PLAN

		CURRENT PLAN	CURRENT PLAN	NEW PLAN
		2020	2020	2021
		Buy-Up Plan	Alternate Plan	Enhanced Plan
		P29E2	P22E2	HRAPC03T7
		IN-NETWORK SUMMARY OF BENEFITS		
Lifetime Max		Unlimited	Unlimited	Unlimited
HRA Dollars		N/A	N/A	$500
Deductible (Individual/Family)		$2500/$5000	$1500/$3000	$1500/$3000
Out of Pocket Max (Individual/Family)		$6600/$13200	$6500/$13000	$3425/6850
Coinsurance		Anthem Pays 80% after Deductible	Anthem Pays 80% after Deductible	Anthem Pays 80% after Deductible
Inpatient Services		Anthem Pays 80% after Deductible	Anthem Pays 80% after Deductible	Anthem Pays 80% after Deductible
Outpatient Surgery		Anthem Pays 80% after Deductible	Anthem Pays 80% after Deductible	Anthem Pays 80% after Deductible
ER Services		$250/20%	$250/20%	Anthem Pays 80% after Deductible
PCP Visit		$25	$25	$30
Specialist		$50	$50	$60
Preventative		Paid 100%	Paid 100%	100%
Retail Drugs 30 Day Supply		10/35/75/25%	10/35/75/25%	Level 1 $10/$35/$75 Level 2 $20/$45/$85

Your summary of benefits

Anthem

ENHANCED PLAN

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HRA (with Copay) Option 3 with Rx Option T7

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,500 person / $3,000 family	$4,500 person / $9,000 family
Out-of-Pocket Limit	$3,425 person / $6,850 family	$10,275 person / $20,550 family
The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility Visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	No charge	0% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *Rx Choice Tiered Network w/R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*			
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	$20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery)	$45 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible does not apply (home delivery)	$85 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to $450 per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Convenience or savings? No need to choose.

You get both with Rx Choice Tiered Network.

With your plan, you have lots of choices about where to get your prescription medicines. And with the Rx Choice Tiered Network, you can choose a pharmacy that saves you money.

Your pharmacy network offers two levels of coverage:

$ Level 1

These are our preferred pharmacies, where your copay or share of the prescription cost is lower. There are more than 25,000* Level 1 pharmacies across the country, including well known chains like:

- CVS
- Target
- Costco
- Kroger
- Meijer
- Sam's Club
- Walmart

$$ Level 2

You'll pay a little more for your prescriptions at a Level 2 pharmacy. There are 40,000* of these around the country, including:

- Walgreens
- Rite Aid

Questions?

Call the Pharmacy Member Services number on the back of your plan ID card.

It's easy to find a pharmacy in the Rx Choice Tiered Network

- Visit anthem.com, choose **Manage Your Prescriptions** and log on.
- On the *Pharmacy* page, choose **Find a Pharmacy**.
- Enter your ZIP code and how far you want to search to find pharmacies near you.

* IngenioRx data, 2019.

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Take care of yourself. Use your preventive care benefits.

Anthem BlueCross BlueShield

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24, with fair skin, about ways to lower their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening[2] when done as part of a preventive care visit

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[3]
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)[4,5]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[5]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[5]
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.

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See a doctor or therapist when it works for you

Using LiveHealth Online, any time works for a video visit with a doctor or therapist.

If you need care for a health issue, or support if you're feeling anxious or having trouble coping on your own, LiveHealth Online is ready to help. You can stay home and have a video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer.

By using LiveHealth Online, you can

- **See a board-certified doctor in a few minutes with no appointment.** Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy.[1] When your own doctor isn't available, use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or another common health condition.
- **Make an appointment with a licensed therapist in four days or less.**[2] You can have a video visit with a therapist from home, at work or on the go — evenings and weekend appointments are available too. Appointments can be scheduled online or over the phone at **1-888-548-3432** from 7 a.m. to 7 p.m., seven days a week. You can get help for anxiety, depression, grief, panic attacks and more.

What will a visit cost?

Your Anthem plan includes benefits for video visits using LiveHealth Online, so you'll just pay your share of the costs — usually $59 or less for medical doctor visits, and a 45-minute therapy session usually costs the same as an office therapy visit.

Sign up for LiveHealth Online today – it's quick and easy

Go to **livehealthonline.com** or download the app and register on your phone or tablet.

Download on the App Store ANDROID APP ON Google play

Anthem LiveHealth ONLINE

How to reach us

Help that goes where you do. Keep us handy:

Employee Assistance Program (EAP)

800-865-1044

Website

anthemEAP.com
Enter KACo to log in.

Free, confidential help

24 hours a day, 7 days a week

You can also find us here:

@AnthemEAP on Twitter

The Wellpost Blog@anthemEAP.com

Your privacy matters. No one will know you've contacted EAP unless you give permission in writing.* Let us give you a helping hand. Just call 800-865-1044 or go to anthemEAP.com and enter KACo to log in.

Anthem

* In accordance with federal and state law, and professional ethical standards.

Language Access Services - (TTY/TDD: 711)
Spanish - Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
Chinese - 您有權使用您的語言免費獲得該資訊和協助。
請撥打您的 ID 卡上的成員服務號碼尋求協助。

Anthem complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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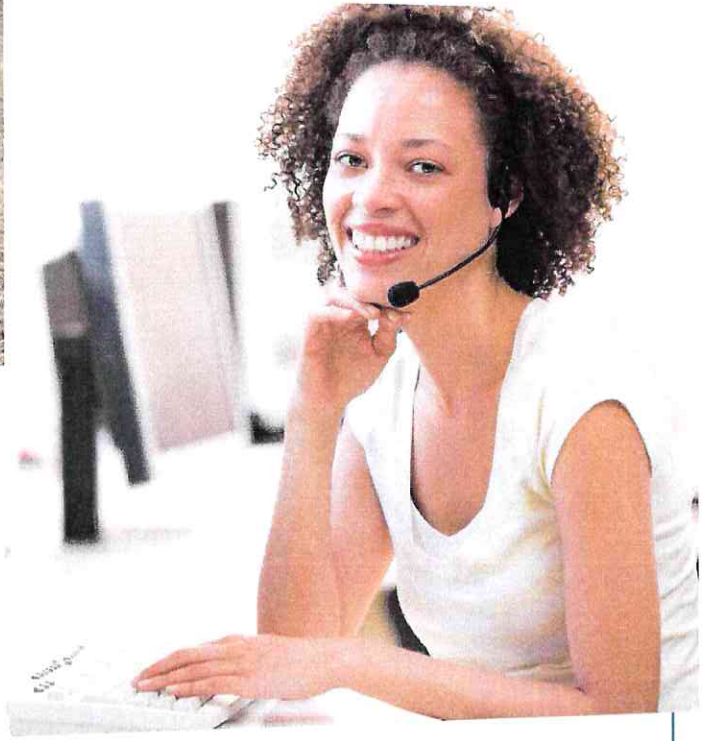
Anthem

Employee Assistance Program

800-865-1044
anthemEAP.com
Enter **KACo**
to log in. Free, confidential help
24 hours a day, 7 days a week.

Welcome to your EAP

We are here when you need us



What's your Employee Assistance Program (EAP)?
We're the folks who can help you meet life's challenges. Call 800-865-1044 or visit anthemEAP.com and enter KACo to log in. Everything you share is confidential and will stay between you and us.*

Anthem

We're here for your everyday problems and questions, big or small.

Take a deep breath. New to town and looking for child, elder or pet care? We can help with that and ...

- Finding work-life balance.
- Parenting a child with special needs.
- Dealing with addiction and recovery.
- Setting retirement goals.
- Getting mental health resources and information.
- Just about anything else life throws at you.

Mark's Story

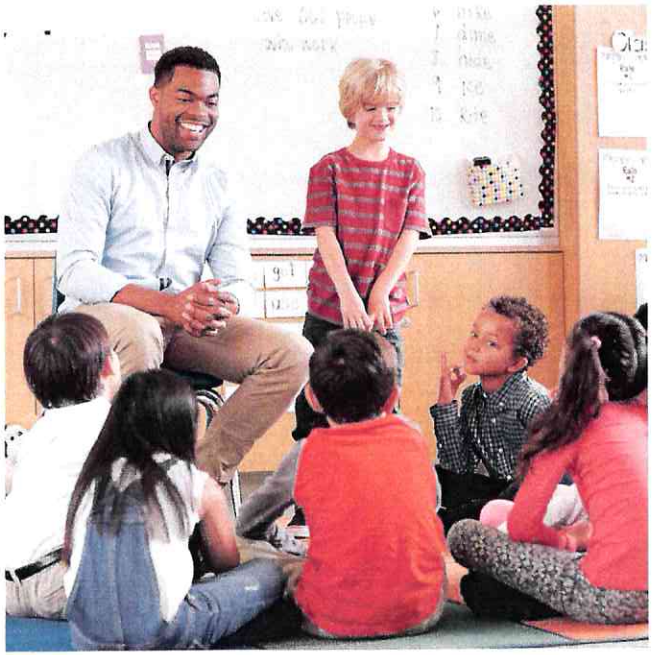
When you need some guidance, one on one that's what EAP's about. Take the case of "Mark," who called us during a difficult financial time:

Mark contacted EAP when he found himself struggling to keep his home. He was stressed and anxious about his financial situation and his ability to find a new place to live. When Mark reached out to EAP, he learned about services that were available to him, including counseling, financial consultation and housing search assistance. The EAP professional Mark spoke with was able to refer him to local counselors who specialized in his areas of need and directed him to emotional health resources on the EAP website to help manage his feelings of stress and anxiety.

Talk to us by phone, in-person or online. You can:

- Use our toll-free number to speak with an EAP professional.
- Meet with a professional face to face.
- Have up to 3 free counseling visits per issue.
- Ask us about online visits with LiveHealth Online.

Get to know your EAP better at anthemEAP.com

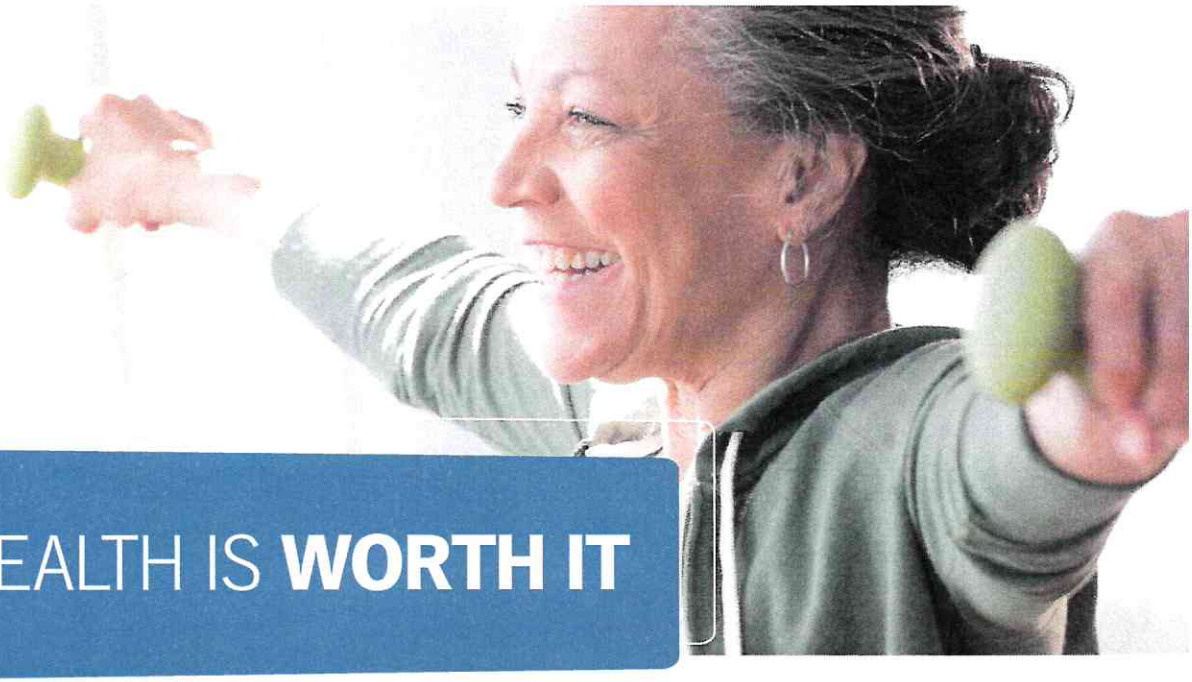


Contact us 24/7.

Simply call 800-865-1044 or visit anthemEAP.com to be connected right away — at no cost to you.

Anthem

Anthem



GOOD HEALTH IS **WORTH IT**

Your guide to earning rewards with Wellbeing Solutions

Your whole health matters. That's why you have Wellbeing Solutions, a suite of programs to help you with your everyday health and well-being. You receive extra guidance and support in managing your health, plus you can earn monetary rewards.

Earn up to **$200 in rewards**

Anthem Health Rewards[1] offers you and your covered spouse or partner up to $200 in rewards for taking part in employer-sponsored health and wellness programs. You will receive your rewards through a reloadable debit rewards card or an account deposit.[2] You can see the status of your progress on anthem.com or download the free Sydney Health mobile app.

Includes

Well-being Coach[3]

Well-being Coach offers multiple options to help you meet your well-being goals. Our digital coaching app offers personalized 24/7 support on the go, whenever you need it. Well-being Coach combines smart technology and proven behavioral therapy techniques to help you maintain a healthy weight or quit tobacco. You can also receive additional help on well-being topics like nutrition, activity, mindfulness and sleep. Well-being Coach is powered by Lark and accessible from the Sydney Health app.

If you prefer a helping hand or require additional support meeting your health goals, Well-being Coach gives you access to a certified Health Coach by phone. You and your coach will identify habits you want to change and develop custom action plans to achieve your health goals. No matter how you connect, you can earn rewards with Well-being Coach.

Rewards you can earn (up to $200 total)

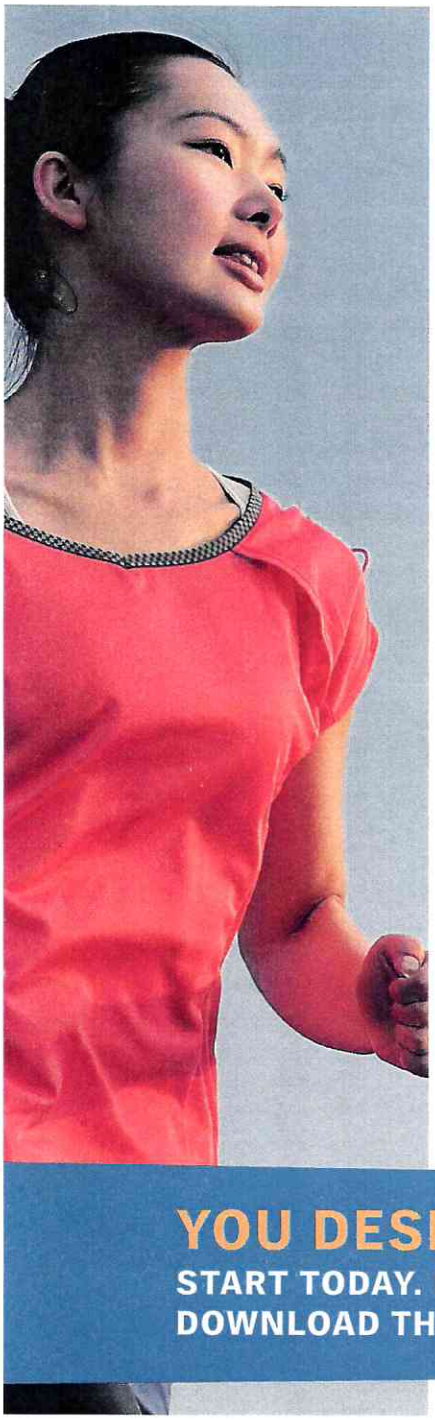
Flu shot and wellness visit reward - **up to $50**

For extra motivation to stay healthy, you can earn $50 in rewards for receiving a claims-based annual preventive wellness exam and flu shot.

Visit your primary care doctor's office for your wellness exam. You can also receive a flu shot at your doctor's office, or at a pharmacy or retail clinic. Your wellness exam or flu shot do not need to be completed in any particular order or together. Be sure to submit the claims to Anthem or ask your doctor or other provider to submit them to Anthem for you.[4]

My Health Rewards Activities - **up to $150**

Keep up healthy habits by tracking your activity through anthem.com, Sydney Health or the Well-being Coach app. You can also track rewards activities through a variety of devices, such as Apple Health Kit, Google Health, and more. Go to the Help section of Sydney Health for a full list of supported devices.



Sydney Health Activities

- Login to website or mobile app - 10 points / yearly
- Connect a tracking device - 15 points / yearly
- Complete the WebMD Health Risk Assessment - 75 points / yearly
- Read five articles or watch five videos - 25 points / yearly (5 points earned at a time)
- Article/video topics include: exercise, healthy eating, sleep, family health, mind & body, what's new, trending, and more
- Set an action plan - 10 points / once per quarter
- Action plans include: Eat Healthy, Achieve a Healthy Weight, Get Active, Increase Energy, Reduce Stress and Sleep Better
- Complete an action plan - 100 points / once per quarter
- Track steps
  - Average 2,000 steps a day - 2 points / monthly
  - Average 5,000 steps a day - 5 points / monthly
  - Average 7,500 steps a day - 10 points / monthly

Well-being Coach Activities

- First completed Mission daily check-in - 10 points
- Achieve 15 completed Mission daily check-ins during the first three months - 15 points
- Achieve 25 completed Mission daily check-ins during the second three months - 25 points
- Achieve 25 completed Mission daily check-ins during third three months - 25 points
- Achieve 25 completed Mission daily check-ins during fourth three months - 25 points

You will receive a reward payout when you reach the milestones of 100, 200 and 300 points. One hundred points equals $50.

Example: First, you receive a reward payout when you reach the 100 point milestone. Then, your points balance resets to zero. To reach the next milestone, you will need to earn 200 points. When you reach this 200 point milestone, you receive a reward payout and your points will reset again to zero. To receive the final reward payout, you will need to earn another 300 points.

YOU DESERVE GOOD HEALTH

START TODAY. REGISTER AT ANTHEM.COM OR DOWNLOAD THE FREE SYDNEY HEALTH MOBILE APP.

Download on the App Store

GET IT ON Google Play

Blue View Vision℠

Ky Association of Counties

Plan FS.B.20.20.130.130

Anthem. BlueCross BlueShield

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$20 copay	Up to $42 reimbursement	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance, then 20% off any remaining balance	Up to $45 reimbursement	Once every two calendar years
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses:			
○ Single vision lenses	$20 copay	Up to $40 reimbursement	Once every calendar year
○ Bifocal lenses	$20 copay	Up to $60 reimbursement	
○ Trifocal lenses	$20 copay	Up to $80 reimbursement	
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
○ Transitions Lenses (for a child under age 19)	$0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
○ Standard polycarbonate (for a child under age 19)	$0 copay		
○ Factory scratch coating	$0 copay		
Contact Lenses *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
○ Elective conventional (non-disposable)	$130 allowance, then 15% off any remaining balance	Up to $105 reimbursement	Once every calendar year
OR			
○ Elective disposable	$130 allowance *(no additional discount)*	Up to $105 reimbursement	
OR			
○ Non-elective (medically necessary)	Covered in full	Up to $210 reimbursement	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	○ Transitions lenses (Adults)
	○ Standard Polycarbonate (Adults)
	○ Tint (Solid and Gradient)
	○ UV Coating
	○ Progressive Lenses[1]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	○ Anti-Reflective Coating[2]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	○ Other Add-ons
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	○ Complete Pair ○ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	○ Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	○ Standard contact lens fitting[3] ○ Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	○ Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available coating brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

Online stores:

GLASSES.COM glasses.com | contactsdirect contactsdirect.com | 1800contacts 1800contacts.com | LENSCRAFTERS lenscrafters.com | OPTICAL targetoptical.com | Ray-Ban ray-ban.com/insurance

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just **log in at anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at **1-866-723-0515** to request a claim form.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111

DAVIS VISION
EYECARE REFRAMED℠

Policy Available for Purchase

Ohio County Fiscal Court

HRI DENTAL

Premier Voluntary Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

Visionworks

IN-NETWORK BENEFITS	
Eye Examination	Every 12 months, **Covered in full** after $10 copayment
Eyeglasses	
Spectacle Lenses	Every 12 months, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses after $25 copayment
Frames	Every 24 months, **Covered in full** Any Fashion, Designer or Premier frame from Davis Vision's Collection[1] (value up to $195) OR $150 retail allowance toward any frame from provider, plus 20% off balance[3] OR $200 allowance, plus 20% off balance[3] to go toward any frame from a Visionworks family of store locations.[5]
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every 12 months, Collection Contacts: **Covered in full** after $25 copay OR Non Collection Contacts: Standard Contacts: **Covered in full** after $25 copay Specialty Contacts: $60 allowance with 15% off balance[3] less $25 copay
Contact Lenses (in lieu of eyeglasses)	Every 12 months, **Covered in full** Any contact lenses from Davis Vision's Contact Lens Collection[1] OR $150 retail allowance toward provider supplied contact lenses, plus 15% off balance[3]

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$25	$0
Polycarbonate Lenses	$66	$0[2]-$30
Standard Anti-Reflective (AR) Coating	$83	$35
Standard Progressives (no-line bifocal)	$198	$50
Photochromic Lenses (i.e. Transitions®, etc.)[4]	$110	$65

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Eye Examination	$103	$10
Lenses		
Bifocals	$116	$25
Scratch-Resistant Coating	$25	$0
Transitions®[5]	$110	$65
Frame	$160	$0
Total	$514	$100

Savings up to: **$414**

[1] *The Davis Vision Collection is available at most participating independent provider locations.*
[2] *For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.*
[3] *Additional discounts not applicable at Walmart, Sam's Club or Costco locations..*
[4] *Transitions® is a registered trademark of Transitions Optical Inc.*
[5] *Enhanced frame allowance available at all Visionworks Locations nationwide.*

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.
- Retinal Imaging available at a $39 Member Charge. Additional pairs of eyeglasses at 30% discount.[3]

Contact Info

For more details about the plan, just log on to the Open Enrollment section of our Member site at davisvision.com or call 1.877.923.2847 and enter Client Code 8129.

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
FRAMES		
Fashion Frame (from the Davis Vision Collection)	$100	$0
Designer Frame (from the Davis Vision Collection)	$160	$0
Premier Frame (from the Davis Vision Collection)	$195	$0
LENSES		
All Ranges of Prescriptions and Sizes	**$90**	**$0**
Plastic Lenses	**$78**	**$0**
Oversized Lenses	**$20**	**$0**
Tinting of Plastic Lenses	**$25**	**$0**
Scratch-Resistant Coating	**$25**	**$0**
Polycarbonate Lenses	$66	$0[1] or $30
Ultraviolet Coating	$25	$12
Standard Anti-Reflective (AR) Coating	$83	$35
Premium AR Coating	$104	$48
Ultra AR Coating	$121	$60
Standard Progressive Addition Lenses	$198	$50
Premium Progressives Addition Lenses	$247	$90
Ultra Progressives Addition Lenses	$369	$140
High-Index Lenses	$120	$55
Polarized Lenses	$103	$75
Photochromic Lenses (i.e. Transitions®, etc.)[2]	$110	$65
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

[1] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

[2] Transitions® is a registered trademark of Transitions Optical, Inc.

[3] Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $40 | Frame up to $50 Spectacle Lenses (per pair) up to: Single Vision $40, Bifocal $60, Trifocal $80, Lenticular $100 Elective Contacts up to $105, Visually Required Contacts up to $225

dental health OPTIONS by Health Resources, Inc.

Product Summary Guide for Dental Health Options Plan 3

Dental Health Options by Health Resources Inc. offers convenient and affordable dental care that provides network savings and protection for your employees through our extensive dental network.

To find a dentist visit: InsuringSmiles.com/FindADentist

PLAN ANNUAL MAXIMUM BENEFIT: $500 - $2,000

DENTAL SERVICES COVERED AT 100% *

PREVENTIVE SERVICES
- Routine teeth cleaning
- Fluoride applications
- Sealants (permanent molar teeth only)
- Space maintainers (not orthodontic retainers)

DIAGNOSTIC SERVICES
- Evaluations (exams)
  - Periodic, limited, comprehensive, periodontal
- Radiographs (x-rays)
  - Complete series
  - Panoramic films
  - Bitewings
- Other procedures
  - Pulp vitality tests
  - Diagnostic casts

DENTAL SERVICES COVERED AT 80% *

RESTORATIVE
- Silver fillings
  - Primary teeth / Permanent teeth
- White fillings
  - Anterior teeth / Posterior teeth

ENDODONTICS
- Root canal therapy
  - Anteriors / Premolars / Molars
  - Retreatment

ORAL SURGERY
- Extractions
  - Routine removals or exposed roots

DENTAL SERVICES COVERED AT 50% *

RESTORATIVE
- Inlay/Onlay (metallic & porcelain)
- Crowns
  - Porcelain/ceramic
  - Full cast/¾ cast
  - Prefabricated stainless steel
  - Recementation
- Other restorative services
  - Protective restoration
  - Core buildup including pins
  - Pin retention
  - Post & core
  - Labial veneers (anterior teeth)

ENDODONTICS
- Vital pulpotomy (primary teeth only)
- Pulp therapy (primary teeth only)
- Apexification
- Apicoectomy
- Root amputation

PERIODONTICS
- Gingivectomy, per quadrant
- Crown lengthening
- Osseous surgery
- Soft tissue grafts
- Distal or proximal wedge
- Scaling and root planing
- Full mouth debridement
- Periodontal maintenance

PROSTHODONTICS
- Removable
  - Complete/Immediate dentures
  - Partial dentures
    - All acrylic
    - Metal framework, acrylic saddles
  - Repairs/Reline
  - Tissue conditioning
- Fixed bridgework
  - Bridge pontics & retainers
  - Resin bonded (Maryland) bridge
  - Recementation
  - Post & core

IMPLANT SUPPORTED PROSTHETICS (RESTORATIONS)
- Removable dentures, abutment supported
- Crowns, abutment supported
  - Porcelain/ceramic/cast metal
- Fixed bridgework, abutment supported
  - Porcelain/ceramic/cast metal

ORAL SURGERY
- Extractions
  - Surgical removals
  - Impactions
- Natural tooth reimplantation
- Surgical exposure or unerupted tooth
- Biopsy, soft tissue
- Incision and drainage of abscess
- Frenectomy
- Excise hyperplastic tissue
- Alveoloplasty (smoothing of bone)

ADJUNCTIVE
- Palliative emergency treatment
- Anesthesia
  - General anesthesia
  - Intravenous sedation
  - Analgesia (nitrous oxide)
- Athletic mouth guards
- Bleaching (anterior teeth, supervised in office)

LIFETIME ORTHODONTIC BENEFIT RIDER: $1,000 - $2,000

Adult & Dependent Children or Dependent Children Only

Procedures listed herein are payable at 50% up to the lifetime maximum benefit. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted her/her lifetime maximum benefit under any Plan, additional charges will be excluded.

- Limited Orthodontic Treatment
- Comprehensive Orthodontic Treatment
- Interceptive Orthodontic Treatment
- Treatment to Control Harmful Habits

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in the Employer group contract and your Member handbook, which are available on our website or by calling HRI at 800-727-1444.

* Applicable to covered services obtained from a network dentist. Non-participating dentists may balance bill.

Coverage against unplanned medical emergencies is surprisingly affordable.

Facts You Should Know

- Emergent Ground Ambulance transports can easily surpass $2,000 and can reach as high as $5,000.
- Emergent Air Ambulance transports frequently cost more than $40,000, reaching as high as $70,000.
- If you are in need of specialized care and can be transported on an non-emergent basis, it is common for a medically equipped plane to cost more than $20,000.
- Most people assume that their health insurance will cover most, if not all, of the costs for these transports. Usually, the opposite is true, leaving you with financially crippling bills.

COVERAGE BENEFIT	EMERGENT PLUS
Emergent Ground Transportation	U.S./Canada
Emergency Air Transportation	U.S./Canada
Medical Repatriation	U.S./Canada

MASA MTS FOR EMPLOYEES protects you when your insurance falls short.

- One low fee for peace of mind for emergent transport costs
- No deductibles
- Easy claim process
- No health questions
- Anyone can join

Coverage includes spouse/domestic partner and dependents up to age 26.

MASA MTS FOR EMPLOYEES provides peace of mind.

Be prepared for the unexpected with a MASA membership. No matter where you live, you could have access to vital emergency medical transportation for a minimal monthly fee. That membership could one day save your life, and, every day, it will give you peace of mind like nothing else.

When is your next medical emergency planned?

Are you prepared?

$7 Per Paycheck

MASA Medical Transport Solutions™

A division of MASA Global.

Any Ground. Any Air. Anywhere.

Employee Navigator

Connecting employees with their benefits

Do you ever forget what your benefits cover?
Do you need a phone number or website for a carrier?
Do you need information about how to file a claim?

Get answers to these questions and more at Employee Navigator. This is a web portal designed to link you with your benefits, providing 24/7 access to your employee benefits information.

Keeping you connected with your benefits is our goal

To log into *Employee Navigator*, go to www.EmployeeNavigator.com and use the login information below:

User Name: Ohio County Fiscal Password: Court

(Please note that User Name and Password are case sensitive)

The following required notifications may be accessed at Employee Navigator:

- Summaries of Benefits and Coverage
- Important Notices Regarding Employee Benefits
- Premium Assistance under Medicaid & Children's Health Insurance Program (CHIP)

If you would like a printed copy of these notices, please notify Anne Melton at 270-298-4402 or Peel and Holland at 270-253-3294.

Peel & Holland

Insurance ▪ Risk Consulting ▪ Employee Benefits

Need Help With Your Benefits?

For *faster* and *confidential* help,
Please contact Anthem or HRI ***first*:**

Anthem

Group Member Services: **1-888-650-4047**
or
Register online at MyAnthem under the Members Link at:
www.Anthem.com

HEALTH RESOURCES, INC.

Customer Care for Dental or Stand Alone Davis Vision
1-800-727-1444
or
Register online under the Members Link at:
www.hri-dho.com

If unable to resolve the issue after contacting Anthem or HRI, then contact:

Peel & Holland
Insurance ▪ Risk Consulting ▪ Employee Benefits

Marla Knight-Dutille
Employee Benefits Consultant
Mknight-Dutille@Peelholland.com
Ph: 270-253-3294
Fax: 815-846-5879

Meghann Lillard, *Account Manager*

Ohio County

David Johnston

Judge Executive

130 East Washington • Suite 215
Hartford, Kentucky 42347
Phone (270) 298-4400 • Fax (270) 298-4408
E-mail: OCJudge@OhioCountyKY.gov

To all County Employees

Dear teammates in serving Ohio County:

It has been the desire of Fiscal Court for some time to find affordable health insurance for your family.

We are offering you the ability to add your spouse at $60 per week, your children for $44 per week or family for $120 per week.

Our insurance committee has been working for months to negotiate this.

Fiscal court is contributing 65% of the cost to allow you the amounts above.

David Johnston

Ohio County Judge Executive