

OH Lumenos Notes

Lumenos Ohio Health Reimbursement Accounts - Blue Access PPO

Group Size 2-50 & 51+ Employer Contribution/HRA Account Proration check box (must select one)

Calendar year benefits

- | | |
|--|--|
| <input type="checkbox"/> Group size 2-50 | <input type="checkbox"/> Group Size 51-99 |
| <input type="checkbox"/> Monthly Proration | <input type="checkbox"/> Monthly Proration |
| <input type="checkbox"/> Quarterly Proration | <input type="checkbox"/> Quarterly Proration |

- | |
|--|
| <input type="checkbox"/> Group size 100+ |
| <input type="checkbox"/> Monthly Proration |
| <input type="checkbox"/> Quarterly Proration |
| <input type="checkbox"/> Annual Proration (Underwriting must be notified for price adjustment) |

Employer Contribution/HRA Account Proration check box (must select one)

Plan year benefits

- | | |
|--|--|
| <input type="checkbox"/> Group size 2-50 | <input type="checkbox"/> Group Size 51-99 |
| <input type="checkbox"/> Monthly Proration | <input type="checkbox"/> Monthly Proration |

- | |
|--|
| <input type="checkbox"/> Group size 100+ |
| <input type="checkbox"/> Monthly Proration |
| <input type="checkbox"/> Annual Proration (Underwriting must be notified for price adjustment) |

Coinsurance applies after the deductible. 0% means no coinsurance up to the maximum allowable amount. Refer to the benefit summary for detailed information. For all Options, no deductible/coinsurance up to the maximum allowable amount for Preventive Care Services (Network only). Non-network Preventive Care Services subject to Non-network cost shares.

Benefit Period = Calendar year or Plan year benefits

Select one

- | | |
|--|--|
| <input type="checkbox"/> Calendar year check box | <input type="checkbox"/> Plan year check box |
|--|--|

The maximum rollover contribution amount will be either 3 times your Employer Health Account contribution or unlimited, based upon the plan design selected.

***Employer must fund in order to be considered a Health Reimbursement Account. Employer must continue to fund for the entire year at the HRA level indicated.**

For Employers that select calendar year benefits and have an effective date other than January 1, the Employer Health Reimbursement Account contribution will be pro rated either monthly or quarterly. For group size 100+ annual pro ration may also be selected.

OH Lumenos Notes

****Bridge is not an insurance term and does not appear in the Certificate. HRA funds can be used for covered services under the benefit plan. Bridge amounts may be reduced if Incentives are earned and by Contribution Rollover amounts in subsequent years. Employer must fund in order to be considered a Health Reimbursement Account. Employer must continue to fund for the entire year at the HRA level indicated**

Should you select a Lumenos HSA or HRA plan in addition to a Core Option, please work with your Anthem Sales Representative to maintain at least a 10% and no more than a 50% pricing spread between the Core and the Buy-up option. In all other situations involving a Core Option and a Buy-up Option, please work with your Anthem Sales Representative to maintain at least a 10% and no more than a 35% pricing spread between the Core and the Buy-up option.

The following Rewards are included for all options:

Completion of Online MyHealth Assessment: \$50

Participation in a Health Coaching Program: \$100

Graduation from a Health Coaching Program: \$200

Participation and completion of Tobacco-Free Program: \$50

Participation and completion of Healthy Weight Program: \$50

Lumenos[®] Health Reimbursement Accounts

Notes:

- Deductible(s) apply only to covered services listed with a percentage (%) coinsurance including prescription drugs cost shares.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required for the family until the family out-of-pocket is satisfied.
- Accidental Dental \$3000. limit.

*Other Outpatient Services include, but are not limited to, Allergy Testing, Physical Medicine Therapy through Day Rehabilitation programs, Ambulance Service, DME, Home Care Services (including Private Duty Nursing), Hospice Care, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Ultrasounds, and Pharmaceutical products.

- **Network and non-Network deductible is combined.**
- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs cost shares.

(Excludes **Non-network** human organ and tissue transplants)

- **Network and Non-network** coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- \$5 million medical lifetime maximum for all covered medical services. However, once the medical lifetime maximum is met, no additional prescription drug claims will be paid.
- Benefit period = calendar year or plan year

Preventive Care Services (Network only) - no cost share up to maximum allowable amount. Non-network Preventive Care Services subject to non-network cost shares.

OH Lumenos Notes

Ambulance/Hospice Facility:

Paid at the **Network** level.

Skilled Nursing Facility (Network and Non-network combined):

Limited to 100 days

Home Care Services (Network and Non-network combined):

Limited to 100 visits (excludes Private Duty Nursing)

Private Duty Nursing – limited to \$50,000 per benefit period with a lifetime maximum of \$100,000

Physical Medicine and Rehabilitation (Network and Non-network combined):

Limited to 60 days and includes Day Rehabilitation programs.

Behavioral Health Services (Network):

Non-biologically based Mental Illnesses and Substance Abuse (Network):

Inpatient: 30 day limit (includes Non-network)

Outpatient: Limited to 30 visits per benefit period

Biologically based Mental Illnesses are paid the same as any other illness.

Mental health/substance abuse limits (Non-network):

Inpatient Mental Health combined with Network day limits.

Outpatient mental health is limited to 10 visits.

Combined inpatient and outpatient substance abuse is limited to \$550.

Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime

(Network and Non-network combined).

Biologically based Mental Illnesses are paid the same as any other illness.

Outpatient Therapy (Network and Non-network combined):

Physical Therapy: 20 visits

Occupational Therapy: 20 visits

Manipulation Therapy: 12 visits

Speech Therapy: 20 visits

Cardiac Rehab: 36 visits

Pulmonary Rehab: 20 visits

OH Lumenos Notes

Durable Medical Equipment and Orthotics (*Network and Non-network combined*):

Subject to benefit maximum of \$4,000 (excluding Prosthetic Devices and Medical Supplies). Prosthetic Devices \$4,000 limit applies. Prosthetic limbs have a \$10,000 limit.

Wigs:

\$500 maximum for wigs due to cancer diagnosis.

Prescription Drug:

30-day supply for **Network** and **Non-network** pharmacy (does not include drugs obtained through mail service pharmacy).

Certain diabetic and asthmatic supplies are not covered at **Non-network** pharmacies (except Diabetic test strips).

Anthem Rx Mail Service:

90-day supply

Non-network not covered.

Rx Mail Order Service - All benefits plans with a 20% medical/Rx coinsurance will have a 10% mail order service coinsurance.

Rx copay Notes - Option Z:

Network cost shares after Deductible: \$10/\$30/\$50/25% with a \$150 per script max on 4 tier. Mail Order - \$10/\$75/\$150/25% with a 4 tier per script max of -\$150 for 30 day supply. Specialty medications will only be dispensed in 30 day increments.

Non Network after deductible: 50% with \$75 minimum copay.

Mandatory Generic

Applies to all products unless otherwise noted. If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent. If the physician indicates no substitutions the member is only responsible for the brand copay.

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Medicare RX Options

Grp Size 2+	Wrap
Grp Size 51+	Wrap, Waiver
Grp Size 100+	Wrap, Waiver, Subsidy

Grp Size 2-99	Dependent Age: Age 19; 24, full-time student End of Calendar Year
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OH Lumenos Notes

Grp Size 100+ Dependent Age:
Age 19 only
Age 19; 21, full-time student
Age 19; 23, full-time student
Age 19; 24, full-time student
Age 19; 25, full-time student
Age 18; 23, federal tax exemption
End of Calendar Year, End of Month, To Birthday

Lumenos Ohio Health Incentive Account + - Blue Access PPO

Group Size 2-50 & 51+ Coinsurance applies **after** the deductible. 0% means no coinsurance up to the maximum allowable amount. Refer to the benefit summary for detailed information. For all Options, no deductible/coinsurance up to the maximum allowable amount for Preventive Care Services (Network only). Non-network Preventive Care Services subject to Non-network cost shares.

Benefit Period = Calendar year or Plan year benefits

Select one

Calendar year check box Plan year check box

The maximum rollover contribution amount will be 3 times your Health Incentive Account + contribution.

***Plan must continue to fund for the entire year at the HIA+ level indicate. For groups that select calendar year benefits and have an effective date other than January 1, the HIA+ contribution will be prorated based on the number of months the member is enrolled.**

****Bridge is not an insurance term and does not appear in the Certificate. HIA+ funds can be used for covered services under the benefit plan. Bridge amounts may be reduced if Incentives are earned and by Contribution Rollover amounts in subsequent years. Plan must continue to fund for the entire year at the HIA+ level indicated**

Should you select a Lumenos HSA, HRA, HIA+ plan in addition to a Core Option, please work with your Anthem Sales Representative to maintain at least a 10% and no more than a 50% pricing spread between the Core and the Buy-up option. In all other situations involving a Core Option and a Buy-up Option, please work with your Anthem Sales Representative to maintain at least a 10% and no more than a 35% pricing spread between the Core and the Buy-up option.

The following Rewards are included for all options:

Completion of Online MyHealth Assessment: \$50

Participation in a Health Coaching Program: \$100

Graduation from a Health Coaching Program: \$200

OH Lumenos Notes

Participation and completion of Tobacco-Free Program: \$50

Participation and completion of Healthy Weight Program: \$50

ASO Groups will have employer Funded Incentives. Fully Insured Group will have incentives paid in the form of a gift card. The amount of the gift card is considered taxable income to the employee. A tax advisor may be consulted for guidance on tax issues.

Lumenos[®] Health Incentive Plus Accounts

Notes:

- Deductible(s) apply only to covered services listed with a percentage (%) coinsurance including prescription drugs cost shares.

Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required for the family until the family out-of-pocket is satisfied. Does not apply to embedded deductible options.

- Accidental Dental \$3000. limit.

*Other Outpatient Services include, but are not limited to, Allergy Testing, Physical Medicine Therapy through Day Rehabilitation programs, Ambulance Service, DME, Home Care Services (including Private Duty Nursing), Hospice Care, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Ultrasounds, and Pharmaceutical products.

- **Network and non-Network deductible is combined.**
- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs cost share.

(Excludes **Non-network** human organ and tissue transplants)

- **Network and Non-network** coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- \$5 million medical lifetime maximum for all covered medical services. However, once the medical lifetime maximum is met, no additional prescription drug claims will be paid.
- Benefit period = calendar year or plan year

Preventive Care Services (Network only) - no cost share up to maximum allowable amount. Non-network Preventive Care Services subject to non-network cost shares.

Ambulance/Hospice Facility:

Paid at the **Network** level.

Skilled Nursing Facility (**Network and Non-network combined**):

Limited to 100 days

Home Care Services (**Network and Non-network combined**):

Limited to 100 visits (excludes Private Duty Nursing)

Private Duty Nursing – limited to \$50,000 per benefit period with a lifetime maximum of \$100,000

Physical Medicine and Rehabilitation (**Network and Non-network combined**):

Limited to 60 days and includes Day Rehabilitation programs.

OH Lumenos Notes

Behavioral Health Services (*Network*):

Non-biologically based Mental Illnesses and Substance Abuse (*Network*):

Inpatient: 30 day limit (includes Non-network)

Outpatient: Limited to 30 visits per benefit period

Biologically based Mental Illnesses are paid the same as any other illness.

Mental health/substance abuse limits (*Non-network*):

Inpatient Mental Health combined with Network day limits.

Outpatient mental health is limited to 10 visits.

Combined inpatient and outpatient substance abuse is limited to \$550.

Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime

(*Network and Non-network combined*).

Biologically based Mental Illnesses are paid the same as any other illness.

Outpatient Therapy (*Network and Non-network combined*):

Physical Therapy: 20 visits

Occupational Therapy: 20 visits

Manipulation Therapy: 12 visits

Speech Therapy: 20 visits

Cardiac Rehab: 36 visits

Pulmonary Rehab: 20 visits

Durable Medical Equipment and Orthotics (*Network and Non-network combined*):

Subject to benefit maximum of \$4,000 (excluding Prosthetic Devices and Medical Supplies). Prosthetic Devices \$4,000 limit applies. Prosthetic limbs have a \$10,000 limit.

Wigs:

\$500 maximum for wigs due to cancer diagnosis.

Prescription Drug:

30-day supply for **Network** and **Non-network** pharmacy (does not include drugs obtained through mail service pharmacy).

Certain diabetic and asthmatic supplies are not covered at **Non-network** pharmacies (except Diabetic test strips).

Anthem Rx Mail Service:

OH Lumenos Notes

90-day supply

Non-network not covered.

Rx Mail Order Service - All benefits plans with a 20% medical/Rx coinsurance will have a 10% mail order service coinsurance.

Rx copay Notes - Option Z:

Network cost shares after Deductible: \$10/\$30/\$50/25% with a \$150 per script max on 4 tier. Mail Order - \$10/\$75/\$150/25% with a 4 tier per script max of -\$150 for 30 day supply. Specialty medications will only be dispensed in 30 day increments.

Non Network after deductible: 50% with \$75 minimum copay.

Mandatory Generic

Applies to all products unless otherwise noted. If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent. If the physician indicates no substitutions the member is only responsible for the brand copay.

Medicare RX Options

Grp Size 2+	Wrap
Grp Size 51+	Wrap, Waiver
Grp Size 100+	Wrap, Waiver, Subsidy

Grp Size 2-99	Dependent Age: Age 19; 24, full-time student End of Calendar Year
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Grp Size 100+	Dependent Age: Age 19 only Age 19; 21, full-time student Age 19; 23, full-time student Age 19; 24, full-time student Age 19; 25, full-time student Age 18; 23, federal tax exemption End of Calendar Year, End of Month, To Birthday
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Lumenos Ohio Health Savings Account - Blue Access PPO

Group Size 2-50 & 51+ Plan Options are integrated with the Mellon HSA Solution. Enrolling in the Lumenos HSA automatically enrolls you in the Mellon HSA solution.

OH Lumenos Notes

If you do not want to enroll in the Mellon HSA solution, you must check the box: do not want to enroll in the Mellon HSA solution

Employer Funded/ASO HSA Incentives: When selecting one of the following HSA plan designs, if the Group does not offer a Section 125/Cafeteria Plan, the employer should consult with a tax advisor to avoid tax penalties.

Coinsurance applies after the deductible. 0% means no coinsurance up to the maximum allowable amount. Refer to the benefit summary for detailed information. For all Options, no deductible and 0% coinsurance up to the maximum allowable amount for Preventive Care Services (Network only). Non-network Preventive Care Services subject to Non-network cost shares.

Benefit Period = Calendar year or Plan year benefits

E = embedded deductible

Select one

Calendar year check box

Plan year check box

NOTE: Employer Funded Incentive contributions to employees' Health Savings Accounts must be made through a section 125 cafeteria plan to comply with IRS comparable contribution requirements.

For Small Groups only (2 – 50): A plan selection within a group of an HRA and an HSA with identical health plan benefits is available in all situations. Also, should you select a Lumenos HSA or HRA plan in addition to a Core Option, please work with your Anthem Sales Representative to maintain at least a 10% and no more than a 50% spread between the Core and the Buy-up option. In all other situations involving a Core Option and a Buy-up Option, please work with your Anthem Sales Representative to maintain at least a 10% and no more than a 35% pricing spread between the Core and the Buy-up option.

The following Rewards are included for all options:

Completion of Online MyHealth Assessment: \$50

Participation in a Health Coaching Program: \$100

Graduation from a Health Coaching Program: \$200

Participation and completion of Tobacco-Free Program: \$50

Participation and completion of Healthy Weight Program: \$50

ASO Groups will have employer Funded Incentives. Fully Insured Group will have incentives paid in the form of a gift card. The amount of the gift card is considered taxable income to the employee. A tax advisor may be consulted for guidance on tax issues.

Lumenos[®] Health Savings Accounts

Notes:

- Deductible(s) apply only to covered services listed with a percentage (%) coinsurance including prescription drugs cost shares.

Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required for the family until the family out-of-pocket is satisfied. Does not apply to embedded deductible options.

- Accidental Dental \$3000. limit.

OH Lumenos Notes

*Other Outpatient Services include, but are not limited to, Allergy Testing, Physical Medicine Therapy through Day Rehabilitation programs, Ambulance Service, DME, Home Care Services (including Private Duty Nursing), Hospice Care, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Ultrasounds, and Pharmaceutical products.

- Network and non-Network deductible is combined.
- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs cost share.

(Excludes Non-network human organ and tissue transplants)

- Network and Non-network coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- \$5 million medical lifetime maximum for all covered medical services. However, once the medical lifetime maximum is met, no additional prescription drug claims will be paid.
- Benefit period = calendar year or plan year

Preventive Care Services (Network only) - no cost share up to maximum allowable amount. Non-network Preventive Care Services subject to non-network cost shares.

Ambulance/Hospice Facility:

Paid at the Network level.

Skilled Nursing Facility (Network and Non-network combined):

Limited to 100 days

Home Care Services (Network and Non-network combined):

Limited to 100 visits (excludes Private Duty Nursing)

Private Duty Nursing – limited to \$50,000 per benefit period with a lifetime maximum of \$100,000

Physical Medicine and Rehabilitation (Network and Non-network combined):

Limited to 60 days and includes Day Rehabilitation programs.

Behavioral Health Services (Network):

Non-biologically based Mental Illnesses and Substance Abuse (Network):

Inpatient: 30 day limit (includes Non-network)

Outpatient: Limited to 30 visits per benefit period

Biologically based Mental Illnesses are paid the same as any other illness.

Mental health/substance abuse limits (Non-network):

Inpatient Mental Health combined with Network day limits.

Outpatient mental health is limited to 10 visits.

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Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime

OH Lumenos Notes

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Outpatient Therapy (Network and Non-network combined):

Physical Therapy: 20 visits

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Manipulation Therapy: 12 visits

Speech Therapy: 20 visits

Cardiac Rehab: 36 visits

Pulmonary Rehab: 20 visits

Durable Medical Equipment and Orthotics (Network and Non-network combined):

Subject to benefit maximum of \$4,000 (excluding Prosthetic Devices and Medical Supplies). Prosthetic Devices \$4,000 limit applies. Prosthetic limbs have a \$10,000 limit.

Wigs:

\$500 maximum for wigs due to cancer diagnosis.

Prescription Drug:

30-day supply for Network and Non-network pharmacy (does not include drugs obtained through mail service pharmacy).

Certain diabetic and asthmatic supplies are not covered at Non-network pharmacies (except Diabetic test strips).

Anthem Rx Mail Service:

90-day supply

Non-network not covered.

Rx Mail Order Service - All benefits plans with a 20% medical/Rx coinsurance will have a 10% mail order service coinsurance.

Rx copay Notes - Option Z:

Network cost shares after Deductible: \$10/\$30/\$50/25% with a \$150 per script max on 4 tier. Mail Order - \$10/\$75/\$150/25% with a 4 tier per script max of -\$150 for 30 day supply. Specialty medications will only be dispensed in 30 day increments.

Non Network after deductible: 50% with \$75 minimum copay.

Mandatory Generic

Applies to all products unless otherwise noted. If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent. If the physician indicates no substitutions the member is only responsible for the brand copay.

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

OH Lumenos Notes

Grp Size 2+	Wrap
Grp Size 51+	Wrap, Waiver
Grp Size 100+	Wrap, Waiver, Subsidy
Grp Size 2-99	Dependent Age: Age 19; 24, full-time student End of Calendar Year
Grp Size 100+	Dependent Age: Age 19 only Age 19; 21, full-time student Age 19; 23, full-time student Age 19; 24, full-time student Age 19; 25, full-time student Age 18; 23, federal tax exemption End of Calendar Year, End of Month, To Birthday

Lumenos Ohio Health Incentive Account - Blue Access PPO

Group Size 2-50 & 51+ Please refer to the Specialty Cost Share Option Sheet (CSOS) for additional dental benefits available for groups of 51+. These forms are available on the Anthem intranet/internet sites.

Coinsurance applies **after** the deductible. Refer to the benefit summary for detailed information. For all Options, no deductible and 0% coinsurance up to the maximum allowable amount for Preventive Care Services (Network only). Non-network Preventive Care Services subject to Non-network cost shares.

Benefit Period = Calendar year or Plan year benefits

Select one

Calendar year check box Plan year check box

The following Rewards are included for all options:

- Completion of Online MyHealth Assessment: \$50
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- Graduation from a Health Coaching Program: \$200
- Participation and completion of Tobacco-Free Program: \$50

OH Lumenos Notes

Participation and completion of Healthy Weight Program: \$50

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Lumenos[®] Health Incentive Accounts

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- Benefit period = calendar year or plan year

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Ambulance/Hospice Facility:

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Skilled Nursing Facility (*Network and Non-network combined*):

Limited to 100 days

Home Care Services (*Network and Non-network combined*):

Limited to 100 visits (excludes Private Duty Nursing)

Private Duty Nursing – limited to \$50,000 per benefit period with a lifetime maximum of \$100,000

Physical Medicine and Rehabilitation (*Network and Non-network combined*):

Limited to 60 days and includes Day Rehabilitation programs.

Behavioral Health Services (*Network*):

OH Lumenos Notes

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Anthem Rx Mail Service:

90-day supply

OH Lumenos Notes

Non-network not covered.

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Rx copay Notes - Option Z:

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Medicare RX Options

Grp Size 2+	Wrap
Grp Size 51+	Wrap, Waiver
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Grp Size 2-99	Dependent Age: Age 19; 24, full-time student End of Calendar Year
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Grp Size 100+	Dependent Age: Age 19 only Age 19; 21, full-time student Age 19; 23, full-time student Age 19; 24, full-time student Age 19; 25, full-time student Age 18; 23, federal tax exemption End of Calendar Year, End of Month, To Birthday
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