

O H I O

Health Incentive Account Plan

Individual

Lumenos[®]

Si necesita asistencia en español, usted puede solicitarla sin costo adicional contactando a su corredor o agente de cuidados de la salud. También puede visitar www.anthem.com/espanol.

Calendar-year deductible

Out-of-Pocket Maximum (including deductible)

Physician Office Services

Prescription Drugs

Retail: 30 days supply. Mail Service: 90-day supply

Preventive Care

Well Child Care

Diagnostic Services

Inpatient Hospital Services

Outpatient Services

Emergency Room

Urgent Care

Ambulance (includes air)

Maternity Services

Optional Maternity Rider

Subject to a 270 day waiting period

Outpatient Therapy Services

Maximum visits per benefit period for network and non-network combined:

- Physical Therapy - 20 visits maximum
- Speech Therapy - 20 visits maximum
- Occupational Therapy - 20 visits maximum
- Manipulation Therapy - 12 visits maximum

Behavioral Health and Substance Abuse

Non-Biologically Based Mental Illness and Substance Abuse limits apply.

Inpatient - 10 days maximum network and non-network combined

Outpatient - 10 visits maximum network and non-network combined

\$550 combined maximum for non-network inpatient and outpatient substance abuse.

Inpatient and outpatient substance abuse is limited to 2 rehabilitation programs per lifetime. Biologically based Mental Illnesses are covered the same as any other illness and limits do not apply.

Home Health Care (Maximum visits per benefit period - 60 visits)

Hospice

Durable Medical Equipment

Human Organ and Tissue Transplant Services

\$1,000,000 Lifetime maximum combined network and non-network transplant provider services. (Kidney and cornea transplants services covered same as any other illness under medical)

Transportation, Lodging and Meals

Lifetime Maximum

Preexisting Waiting Period

Blue Preferred[®] Term Life Option Available

Dental Blue[®] Option Available

Mail order and prescription drug benefits administered by WellPoint NextRx.

PLAN 1		PLAN 2	
NETWORK YOU PAY	NON-NETWORK YOU PAY	NETWORK YOU PAY	NON-NETWORK YOU PAY
\$1,000 individual / \$2,000 family ²	\$2,000 individual / \$4,000 family ²	\$1,000 individual / \$2,000 family ²	\$2,000 individual / \$4,000 family ²
\$2,500 individual / \$5,000 family ²	\$5,000 individual / \$10,000 family ²	\$2,500 individual / \$5,000 family ²	\$5,000 individual / \$10,000 family ²
\$5,000 individual / \$10,000 family ²	\$10,000 individual / \$20,000 family ²		
\$1,000 individual / \$2,000 family ³	\$3,000 individual / \$6,000 family ³	\$3,000 individual / \$6,000 family ³	\$9,000 individual / \$18,000 family ³
\$2,500 individual / \$5,000 family ³	\$7,500 individual / \$15,000 family ³	\$5,000 individual / \$10,000 family ³	\$15,000 individual / \$30,000 family ³
\$5,000 individual / \$10,000 family ³	\$15,000 individual / \$30,000 family ³		
0% ¹	30% ¹	20% ¹	40% ¹
0% ¹	30% ¹	20% ¹	40% ¹
0% not subject to deductible	30% ¹	0% not subject to deductible	40% ¹
0% not subject to deductible	30% ¹	0% not subject to deductible	40% ¹
0% ¹	30% ¹	20% ¹	40% ¹
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0% ¹	0% ¹	20% ¹	20% ¹
0% ¹	0% ¹	20% ¹	20% ¹
0% ¹	0% ¹	20% ¹	20% ¹
Not Covered	Not Covered	Not Covered	Not Covered
0% ¹	30% ¹	20% ¹	40% ¹
0% ¹	30% ¹	20% ¹	40% ¹
0% ¹	30% ¹	20% ¹	40% ¹
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0% ¹	30% ¹	20% ¹	40% ¹
0% ¹	30% ¹	20% ¹	40% ¹
0% ¹	0% ¹	20% ¹	20% ¹
0% ¹	30% ¹	20% ¹	40% ¹
0% ¹	30% ¹ (Non-network transplant facility)	20% ¹	40% ¹ (Non-network transplant facility)
0% ¹	30% ¹	20% ¹	40% ¹
Unlimited	Unlimited	Unlimited	Unlimited
12 months	12 months	12 months	12 months
YES	YES	YES	YES
YES	YES	YES	YES

Lumenos Health Incentive Account Plan

- ¹ Services subject to calendar-year deductible. Network and Non-network deductibles are separate and do not accumulate towards each other.
- ² The family deductible must be satisfied by either one or all members collectively before any covered services will be paid by the plan.
- ³ Once the family out-of-pocket maximum is satisfied by either one or all members collectively, no additional coinsurance will be required for the family for the remainder of the benefit period.

These plans are available with the Blue Access[®] PPO network. To find a doctor or local hospital, visit www.anthem.com and select the "Find a Doctor" button for a complete list of providers within the network.

This Lumenos HIA Plan Benefits Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits 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 Lumenos HIA Plan Benefits Guide, the terms of the contract or certificate of coverage will prevail.

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And now—some really important legal information you should take the time to read.

Who can apply.

You can apply for Lumenos® HIA Plan coverage for yourself or with your family. Family health coverage includes you, your spouse and any dependent children. Children are covered to the end of the month in which they turn 25. You must be a resident of the state in which you are applying, a legal resident of the U.S. and not currently pregnant.

What's a preexisting condition?

This medical plan covers preexisting conditions after you've been enrolled in the plan for 12 months. A preexisting condition is any medical or physical condition you had in the six months right before you enrolled. If you received medical advice, a diagnosis, care or treatment for the condition – or if it was recommended that you do so – that qualifies it as “preexisting”.

What we do not cover.

Lumenos HIA Plans don't provide benefits for services, supplies or charges having to do with preexisting conditions (see definition for a preexisting condition); private duty nursing; experimental or investigative treatment; dental and vision, except as spelled out in your contract; charges above 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; 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; and services we determine aren't medically necessary.

These are some of the exclusions contained in the plans. Check your contract or certificate of coverage for a complete listing of benefits, exclusions and maximum payment levels.

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, KY 40232-3200

If we uphold our decision throughout the appeals process, you can request a review by the Ohio Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Ohio. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or other family member.

We want you to be satisfied.

If you aren't satisfied with your Lumenos HIA Plan 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.

Information about our Network Providers.

Using our network.

To be eligible to receive the maximum benefits available, you must use network providers. (Please refer to your provider directory, located on www.anthem.com, for a list of network providers.)

Notice of provider arrangements.

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

Accessing Covered Services.

Some services, or supplies, such as prescription drugs, require your doctor to receive an authorization from Anthem that defines and/or limits the conditions under which the service, or supply, will be covered to help you avoid any unnecessary out-of-pocket expenses. Other services, such as organ transplants, require your physician to certify, and for us to approve the service as medically necessary and the appropriate setting. Neither process is a guarantee of coverage.

Non-network provider.

If you receive covered services from a non-network provider, you are responsible for the difference between the actual charge billed and the maximum allowable amount plus any deductible, copayments and non-covered charges.

Some definitions—so we're all on the same page.

A **premium** is the amount of money you pay on a regular basis—once a month, four times a year, twice a year or once a year—to your insurance company to keep your health plan active. You can't apply what you pay for your premium toward your deductible.

A **deductible** is the amount of out-of-pocket expenses you have to pay each year before your health plan kicks in and starts paying for services.

A **coinsurance level** is 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 the deductible has been reached.

An **out-of-pocket limit** is the total amount of money (not counting your premiums) you have to pay each year for your healthcare coverage. Your deductible and coinsurance payments for covered services count toward your out-of-pocket limit.

A **discount** is the reduced out-of-pocket cost you enjoy when you obtain healthcare services from a network provider.

A **drug formulary** is a list of brand-name and generic medications that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. You may help control the amount you pay for prescriptions by encouraging your doctor to prescribe medications from the Anthem formulary on our website at www.anthem.com.