

## Lumenos HSA Plan Coverage

**OPTION: 0% Coinsurance**

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

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

**PLAN LIFETIME MAXIMUM**

**OPTION: 20% Coinsurance**

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

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

**PLAN LIFETIME MAXIMUM**

Network					Non-Network				
YOU PAY 0% Coinsurance					YOU PAY 30% Coinsurance				
Individual:	\$1,500	\$3,000	\$3,500	\$5,000	Individual:	\$1,500	\$3,000	\$3,500	\$5,000
	\$1,500	\$3,000	\$3,500	\$5,000		\$3,000	\$6,000	\$7,000	\$10,000
Family:	\$3,000	\$6,000	\$7,000	\$10,000	Family:	\$3,000	\$6,000	\$7,000	\$10,000
	\$3,000	\$6,000	\$7,000	\$10,000		\$6,000	\$12,000	\$14,000	\$20,000
\$7,000,000 per member for Network and non-network services combined									
YOU PAY 20% Coinsurance					YOU PAY 40% Coinsurance				
Individual:	\$1,750				Individual:	\$1,750			
	\$5,000					\$10,000			
Family:	\$3,500				Family:	\$3,500			
	\$10,000					\$20,000			
\$7,000,000 per member for network and non-network services combined									

## Lumenos HSA Plan Benefits<sup>1</sup>

### DOCTORS' OFFICE VISITS

### PREVENTIVE CARE

*(includes well-child care, preventive office exams, immunizations, PSA screening, Pap smears, mammograms, colorectal cancer exams, colonoscopy, sigmoidoscopy; child immunizations are covered at 100% from birth thru age 5 in network)*

### DIAGNOSTIC SERVICES

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

### EMERGENCY ROOM SERVICES

### MATERNITY

### DENTAL

### LIFE

Network					Non-Network				
YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED					YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED				
0% or 20% Coinsurance <sup>2</sup>									
0% Coinsurance:									
Individual:	\$3,500								
Family:	\$7,000								
20% Coinsurance:									
Individual:	\$1,750				30% or 40% Coinsurance <sup>2</sup>				
Family:	\$3,500								
0% Coinsurance (deductible waived):									
Individual:	\$1,500	\$3,000	\$5,000						
Family:	\$3,000	\$6,000	\$10,000						
0% or 20% Coinsurance <sup>2</sup>					0% or 20% Coinsurance <sup>2</sup>				
Not covered <i>(optional maternity rider available for plans with deductibles of \$2,500 and greater; subject to 12-month waiting period)</i>					Not covered				
Coverage available at additional cost					Coverage available at additional cost				

## Lumenos HSA Drug Coverage

**INCLUDES DRUG COVERAGE UNDER MEDICAL PLAN**

*Note: Specialty injectable drugs are limited to a 30-day supply, available through Anthem's Specialty Rx network, and are not covered out-of-network.*

Network					Non-Network				
YOU PAY YOUR SHARE AFTER DEDUCTIBLE					YOU PAY YOUR SHARE AFTER DEDUCTIBLE				
0% or 20% Coinsurance <sup>2</sup>					30% or 40% Coinsurance <sup>2</sup>				

### OTHER COVERED BENEFITS INCLUDE BUT ARE NOT LIMITED TO:

- Ambulance
- Hospice Care
- Skilled Nursing Care
- Chiropractic
- Organ Transplants
- Speech Therapy
- Durable Medical Equipment
- Rehabilitation Facilities
- Therapy Services
- Urgent Care
- Home Health Care

<sup>1</sup>UNLESS OTHERWISE NOTED, ALL BENEFITS ARE SUBJECT TO THE CALENDAR YEAR DEDUCTIBLE.

<sup>2</sup>COINSURANCE IS DESIGNATED BY THE PLAN YOU CHOOSE.

**IMPORTANT:** This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the contract or certificate of coverage. In the event of a conflict between the contract or certificate of coverage and this Lumenos HSA Benefit Guide, the terms of the contract or certificate of coverage will prevail.

# Understanding Lumenos<sup>®</sup> HSA Coverage

## Preventive Care

Anthem's Lumenos plans cover preventive services recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The preventive care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions in advance and help keep you healthier in the long run.

All preventive services received from a network provider are covered at the coinsurance listed in the benefit summary chart. If you see a non-network provider, then your deductible and non-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes – for example, colonoscopy when symptoms are present – the appropriate plan deductible and coinsurance will apply and available health account dollars may be used to cover these costs.

### Child - Preventive care

Preventive physical exams

Immunizations

Screening tests including the following:

- Eye chart vision screening
- Hearing screening
- Screening for lead exposure
- Pelvic exam and Pap test (if recommended by your doctor)

### Adult - Preventive care

Preventive physical exams

Immunizations

Screening tests including the following:

- Eye chart vision screening
- Hearing screening
- Cholesterol and lipid level screening
- Blood glucose test to screen for Type 2 diabetes
- Prostate cancer screenings including digitalrectal exam and PSA test
- Breast exam and mammography screening
- Pelvic exam and Pap test

Is your doctor or dentist in one of our networks?

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

## Some definitions

### So we're all on the same page

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. Network and non-network deductibles are separate and do not accumulate towards each other.

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 your 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 covered medical services. Your deductible and coinsurance payments for covered services count toward your out-of-pocket limit. Network and non-network out-of-pocket limits are separate and do not accumulate towards each other.

A **discount** is the reduced out-of-pocket cost you enjoy when you obtain covered health care 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 [anthem.com](http://anthem.com).

## About our network providers

### Using our network

To be eligible to receive the maximum benefits available, you must use network providers. To find a doctor, please go to [anthem.com](http://anthem.com) > "Find a Doctor".

### Notice of provider arrangements

Your network 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.

### Out-of-network provider

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

### Networks available

- PPO network
- POS network

## For more complete coverage

### Dental and Term Life Insurance

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

# Anthem

## Lumenos<sup>®</sup> HSA

### Benefit Guide for **Wisconsin**

#### Who can apply?

You can apply for Lumenos HSA coverage for yourself or with your family. You must be a resident of the state in which you are applying, under the age of 65, a legal resident of the U.S. and not currently pregnant. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn 25.

#### What's a preexisting condition?

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

If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the 12-month waiting period. Anthem Blue Cross and Blue Shield will credit the time you were enrolled on the previous plan.

#### What is not covered by Wisconsin Individual Lumenos HSA plans.

Lumenos HSA plans don't provide benefits for services, supplies or charges having to do with preexisting conditions (see "What's a preexisting condition?"); private duty nursing; maternity, unless optional maternity rider is purchased; experimental or investigative treatment; dental and vision, except as spelled out in your contract; treatment of mental health and substance abuse; charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services); care provided by a member of your family; treatment that's primarily intended to improve your appearance; weight loss programs or treatment of obesity; hearing aids; eyeglasses or contact lenses; radial keratotomy or keratomileusis or excimer laser photo; artificial insemination, fertilization, infertility drugs or sterilization reversal; sex transformation surgery; custodial care; artificial and mechanical hearts; workers' compensation; Joint Disorders and services we determine aren't medically necessary.

#### Limitations:

The following outpatient services are limited to 20 visits combined in-network and out-of-network:

- speech therapy
- physical therapy
- occupational therapy
- Home health care services limited to 60 visits.
- Optional maternity rider subject to a 12-month waiting period.
- Preexisting conditions subject to a 12-month waiting period.

These are just some of Lumenos HSA plans' limitations and exclusions. Check your contract or certificate of coverage for a complete listing of benefits, exclusions and maximum payment levels.

#### Our appeal rights & 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. You may contact Customer Service if you have questions concerning the denial. You may also file a grievance by sending a letter to us. You should send any additional information that supports your grievance and state all the reasons why you feel the grievance request should be granted. We will review your grievance and let you know our decision in writing, usually within 30-60 days of receiving your grievance. You may also have the right to request an external review. For more information on the grievance and external review of other rights, please review your contract or certificate of coverage.

If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board-eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal. Please call customer service or check your contract or certificate of coverage for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to: **Anthem Blue Cross and Blue Shield, Appeals Coordinator, P.O. Box 33200, Louisville, Kentucky 40232-3200**

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

#### We want you to be satisfied.

If you aren't satisfied with your Lumenos HSA coverage, you can cancel it within 30 days after you receive your contract or certificate of coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your contract or certificate of coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

This brochure is only a summary of Lumenos HSA benefits and is not a part of the contract or certificate of coverage. If you are approved for coverage, the contract or certificate of coverage you receive will include all the details of your plan. In the event of a conflict between the information in this brochure and your contract or certificate of coverage, the terms of your contract or certificate of coverage will prevail. Please read your contract or certificate of coverage carefully. Anthem has the right to rescind, cancel, terminate or reform coverage based on provisions described in contract or certificate of coverage.

*Blue Cross Blue Shield of Wisconsin ("BCBSWI") underwrites or administers the PPO and indemnity policies, Compare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWI collectively underwrite or administer the POS policies. Life and disability products are underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.*