



Health. Join In.

Individual and Family Health Care Plans
for **Ohio**

Our plans fit your plans



Lumenos[®] HSA
SmartSense[®]



Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on – coverage designed to help fit your budget, and your way of life.

For over 70 years, Anthem Blue Cross and Blue Shield has provided health care coverage and security to our Ohio neighbors. And now, we're pleased to offer these same Individual health care plans with added benefits and features of the Patient Protection and Affordable Health Care Act.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

Sounds like a plan.

Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- **One of the largest provider networks in Ohio.** With more than 20,000 doctors and specialists and over 170 hospitals throughout the state, chances are your doctor is in one of our networks.
- **A choice of plans to help fit your budget and lifestyle.** No matter where you are in life, we've got a plan designed to help fit your health coverage needs, as well as your budget.
- **Optional dental and life insurance.** To enhance your health, we also offer dental and term life coverage and make it easy to enroll.
- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. And network providers in the BlueCard® program across the country will help make it easy to get access to the care you need.
- **ConditionCare** to provide one-on-one help from trained professionals in managing chronic conditions like asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease and heart failure.
- **Future Moms**, a program designed to help you have a healthy pregnancy. While not maternity coverage, Future Moms provides educational materials, certain screenings and 24/7 phone access to registered nurses.

Why do you need health care coverage?

These days, a single day in the hospital can cost thousands of dollars. The financial risk you take without health coverage just isn't worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you're protected against the high cost of unexpected medical bills.

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 20,000 doctors and more than 170 hospitals and other facilities, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

Cost-Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the cost, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copayment is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for in-network covered services. Once you reach this maximum, the plan pays at 100% for most covered services for the rest of the calendar year.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

Brand Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Tiers represent a cost level within the generic and brand name prescription drug categories. The prescription drug coverage under your health care plan will differ for each of these tiers. Not all products have this tiering.

- **Tier 1:** These drugs generally include generic drugs and a few lower cost brand name drugs.
- **Tier 2:** These drugs generally include higher cost generic and brand name drugs.
- **Tier 3 and 4:** These drugs include the highest cost brand name drugs.

Formulary is a list of prescription drugs our health care plans cover. They include generic and preferred brand name drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans. Formulary lists can be found at [anthem.com](https://www.anthem.com).

Health Savings Account (HSA) is a special bank account that can be set up by a member enrolled in a qualified HSA-compatible high-deductible health plan if they choose. Contributions to this account can be made with certain tax advantages and funds from the account can be used for qualified health care expenses. See the insert from our preferred banking partner for more details and consult your tax advisor.

Lumenos[®] HSA

Is this the right plan for you?

Lumenos HSA health plans were designed to give you more control over your health care costs. They help you focus on getting healthy and staying that way.

Lumenos HSA Plan Highlights

This plan offers traditional health care benefits that can be paired with a Health Savings Account (HSA) for more flexibility and potential tax advantages. Simple plan designs make using them that much easier.

Features:

- Preventive care benefits that help you focus on staying healthy.

Anthem 360 Health[®]

- MyHealth@Anthem[®]: Health assessments, resource centers, and health calculators so you see progress and stay motivated.
- 24/7 NurseLine: Health information from a registered nurse whenever you need it.
- MyHealth Coach: Personal help with a wide range of health needs, primarily high blood pressure, high cholesterol, low back pain, musculoskeletal issues like arthritis, and certain types of cancer.
- Healthy Lifestyles Programs: Our proven “Tobacco-Free” and “Healthy Weight” programs help you adopt new habits for a healthy lifestyle with personalized support and educational resources.
- SpecialOffers@AnthemSM: Members-only discounts help you stretch your health account even further with savings on services and products that promote a healthy lifestyle.

You should know:

- Maternity benefits are not available with this plan.
- Your Lumenos HSA plan has a policy-level deductible and out-of-pocket maximum. Once any combination of covered members on the policy meet these amounts, the plan pays 100% of covered expenses. It's that simple.
- While Lumenos HSA is compatible with a Health Savings Account, your health care plan works with or without it. You may set up the HSA now, later, or not at all. It's your choice.

Prescription Drug Coverage

Lumenos HSA not only puts you in charge of your health care dollars, it can help you use those dollars for generic and brand name prescription drugs in the way that best suits you.

Once your deductible is met, there is a coinsurance, if applicable, for covered prescription drugs. But even while you are meeting your deductible, you benefit from lower negotiated rates on prescription drugs at network pharmacies nationwide. There's no need to have a different deductible or copayment for prescriptions; it all works as one.

And since you decide how to spend it, your Health Savings Account dollars can be used to pay for prescription drugs – either while you are meeting your deductible, or afterward for those drugs not covered, like most over-the-counter medications.

How to Customize your Lumenos HSA Plan

Choose your deductible: You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you. Remember, any covered member can contribute to some or all of the policy deductible and out-of-pocket maximum, whether the policy covers one member or a whole household.

Use your Health Savings Account the way you want: Your HSA, if you choose to open one, is funded by you. So, it is yours to use for qualified health care expenses covered by the plan, or those not covered at all, like contact lenses. Your HSA is also yours to keep if you ever leave the plan; you won't lose those dollars if they're not used. In fact, the carryover from year to year can help you save for future financial needs. See the enclosed insert from our preferred banking partner for more information.

Other Optional Coverage: You can add more protection for you and your family by purchasing optional dental benefits, and life insurance. See your Benefit Guide and the dental and life information in the back of this brochure for more details.

Benefits

Calendar Year Deductible

Individual	NETWORK:
	NON-NETWORK:
Family	NETWORK:
	NON-NETWORK:

Network Coinsurance Options

Calendar Year Out-of-Pocket Maximum

Individual	NETWORK:
	NON-NETWORK:
Family	NETWORK:
	NON-NETWORK:

How family deductibles and family out-of-pocket maximums work

Plan Lifetime Maximum

Covered Services

Doctors' Office Visits

Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)

Inpatient Services (overnight hospital/facility stays)

Outpatient Services (without overnight hospital/facility stays)

Emergency Room Services

Preventive Care Services

Maternity

Optional Coverage (at additional cost)

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Optional Drug Coverage (when available)

Other Covered Benefits include but are not limited to:

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/Certificate of Coverage. In the event of a conflict between the Contract/Certificate of Coverage and this Benefit Guide, the terms of the Contract/Certificate of Coverage will prevail.

Lumenos® HSA

Your Choices

	\$1,500	\$1,500	\$1,750	\$2,500	\$3,500	\$5,500
	\$1,500	\$1,500	\$1,750	\$2,500	\$3,500	\$5,500
	\$3,000	\$3,000	\$3,500	\$5,000	\$7,000	\$11,000
	\$3,000	\$3,000	\$3,500	\$5,000	\$7,000	\$11,000

0%	50%	20%	0%	0%	0%
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Add Your Chosen Deductible to the Amount Below

	\$0	\$2,500	\$3,250	\$0	\$0	\$0
	\$1,500	\$6,500	\$8,250	\$2,500	\$3,500	\$5,500
	\$0	\$5,000	\$6,500	\$0	\$0	\$0
	\$3,000	\$13,000	\$16,500	\$5,000	\$7,000	\$11,000

For family coverage, either one or more members must meet the family deductible before any covered services that are subject to the deductible will be paid by the plan. The family out-of-pocket maximum can be met by either one or more members. Once the maximum is met, no additional coinsurance will be required for the family for the remainder of the calendar year.

Unlimited

Your Share of Costs (after deductible, unless waived or not subject to deductible)

NETWORK: 50%, 20% or 0% Coinsurance¹
NON-NETWORK: 50%, 40% or 40% Coinsurance¹

NETWORK: 50%, 20% or 0% Coinsurance¹
NON-NETWORK: 50%, 40% or 40% Coinsurance¹

NETWORK: 50%, 20% or 0% Coinsurance¹
NON-NETWORK: 50%, 40% or 40% Coinsurance¹

NETWORK: 50%, 20% or 0% Coinsurance¹
NON-NETWORK: 50%, 40% or 40% Coinsurance¹

NETWORK: 50%, 20% or 0% Coinsurance¹
NON-NETWORK: 50%, 20% or 0% Coinsurance¹

Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more.
NETWORK: 0% Coinsurance, not subject to deductible
NON-NETWORK: 50%, 40% or 40% Coinsurance¹

Not Covered

Dental, Life

Lumenos HSA

NETWORK: 50%, 20% or 0% Coinsurance¹
NON-NETWORK: 50%, 40% or 40% Coinsurance¹

Not Available

Ambulance, Chiropractic, Durable Medical Equipment, Home Health Care, Hospice Care, Mental Health, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Substance Abuse, Therapy Services, Urgent Care

¹ Coinsurance is designated by the plan you choose.

NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.

SmartSense® Is this the right plan for you?

SmartSense was designed to offer affordable, solid protection without a lot of bells and whistles that may not be important to you.

SmartSense Plan Highlights

SmartSense offers affordable price options, solid protection that covers essentials and even some immediate benefits before the deductible.

Features:

- Immediate coverage with predictable copayments for the first three Doctors' Office Visits, per plan member, each calendar year.
- Choice of prescription drug coverage options.
- Preventive care benefits that help you focus on staying healthy.

You should know:

- Maternity benefits are not available with this plan.
- After the first three Doctors' Office Visits, all other visits apply toward your deductible.
- Generic and select brand name drugs are also available before the deductible, with a copayment or coinsurance.

Prescription Drug Coverage

SmartSense includes coverage for generic and select brand name drugs.

For an additional cost, you can upgrade the SmartSense prescription benefit to expand the coverage for brand name drugs. There is a separate deductible for brand name drugs when you choose the prescription drug upgrade.

See your Benefit Guide for more details.

How to Customize your SmartSense Plan

With SmartSense, you have some choice and flexibility to change the plan to better meet your needs. SmartSense offers a choice of:

Deductible: You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: SmartSense offers a choice of coinsurance levels depending on the deductible you choose, allowing you to vary your level of cost-sharing. You can lower your premium if you choose a higher coinsurance level.

Prescription Drug Benefit: You can customize your plan by selecting the prescription drug upgrade option, as described above.

Dental Coverage and Life Insurance: Add protection for your smile and your wallet. See your Benefit Guide and the dental and life information in the back of this brochure for more details.

Benefits

Calendar Year Deductible

Individual	NETWORK:
	NON-NETWORK:
Family	NETWORK:
	NON-NETWORK:

Network Coinsurance Options

Calendar Year Out-of-Pocket Maximum

Individual	NETWORK:
	NON-NETWORK:
Family	NETWORK:
	NON-NETWORK:

How family deductibles and family out-of-pocket maximums work

Plan Lifetime Maximum

SmartSense®

Your Choices

	\$500	\$1,000	\$1,500	\$2,500	\$3,500	\$5,000	\$10,000
	\$500	\$1,000	\$1,500	\$2,500	\$3,500	\$5,000	\$10,000
	\$1,000	\$2,000	\$3,000	\$5,000	\$7,000	\$10,000	\$20,000
	\$1,000	\$2,000	\$3,000	\$5,000	\$7,000	\$10,000	\$20,000
	30% or 50%	30% or 50%	30% or 50%	30% or 50%	30%	30%	30%

Add Your Chosen Deductible to the Amount Below

	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500
	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500
	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000
	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000

Each family member has an individual deductible and out-of-pocket maximum. The family deductible and out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual deductible or out-of-pocket maximum.

Unlimited

Covered Services

Doctors' Office Visits

NETWORK:
 • **Office Visit Copayment for first 3 visits: \$35 Copayment**, deductible waived, for first 3 visits per member per calendar year for primary care physician/specialist. Other office services are subject to deductible and coinsurance.
 • **Office Visit Coinsurance for 4+ visits and Other Services: 30% or 50% Coinsurance¹**
NON-NETWORK: 50% Coinsurance

Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)

NETWORK: 30% or 50% Coinsurance¹
NON-NETWORK: 50% Coinsurance

Inpatient Services (overnight hospital/facility stays)

NETWORK: 30% or 50% Coinsurance¹
NON-NETWORK: 50% Coinsurance

Outpatient Services (without overnight hospital/facility stays)

NETWORK: 30% or 50% Coinsurance¹
NON-NETWORK: 50% Coinsurance

Emergency Room Services

NETWORK: 30% or 50% Coinsurance¹
NON-NETWORK: 30% or 50% Coinsurance¹

Preventive Care Services

Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more.
NETWORK: 0% Coinsurance, not subject to deductible
NON-NETWORK: 50% Coinsurance

Maternity

Not Covered

Optional Coverage (at additional cost)

Dental, Life

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Standard Drug Coverage:

NETWORK:
 • **For Drugs on Formulary:** Greater of **\$15 Copayment or 40% Coinsurance**
 • **For Drugs Not on Formulary:** Member is responsible for entire cost after applied Anthem negotiated discount.
NON-NETWORK:
 • **For Drugs on Formulary:** Greater of **\$15 Copayment or 40% Coinsurance**. Member is also responsible for difference between Anthem allowable charge and actual cost of drug.
 • **For Drugs Not on Formulary:** Member is responsible for entire cost.

Optional Drug Coverage (when available)

Upgrade Drug Coverage: Separate \$250 per member deductible for Tiers 2, 3 and 4. Member is also responsible for the difference in allowable charge between Brand and Generic, plus copayment or coinsurance.
NETWORK:
 • **Retail Drugs (30 day supply):** Tier 1 (**\$15 Copayment**; Mail Order (90 day supply): **\$30 Copayment**)/Tier 2, 3, and 4 (**\$30 Copayment or 40% Coinsurance**; separate \$4,000 annual Prescription Drug out-of-pocket maximum)
NON-NETWORK: Retail (30-day supply only): **50% Coinsurance** (minimum **\$60**) per prescription. Mail Order not covered.

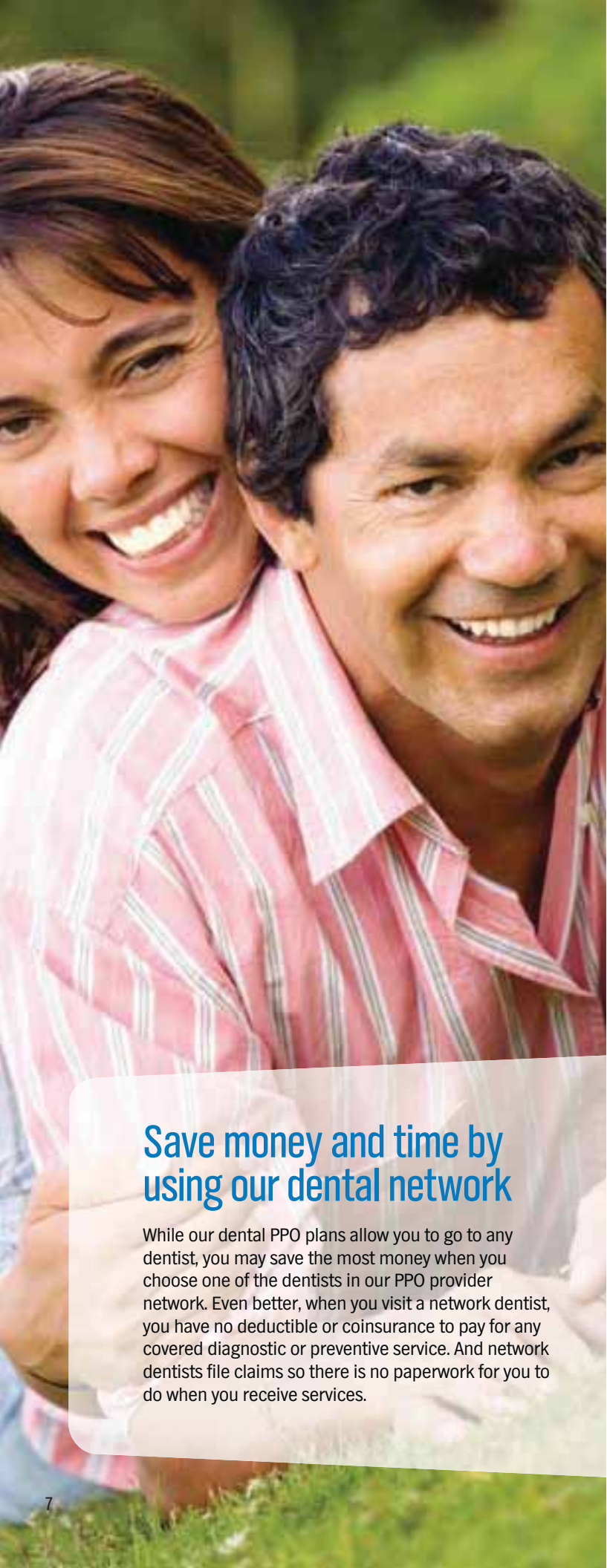
Other Covered Benefits include but are not limited to:

Ambulance, Chiropractic, Durable Medical Equipment, Home Health Care, Hospice Care, Mental Health, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Substance Abuse, Therapy Services, Urgent Care

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¹ Coinsurance is designated by the plan you choose.

NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.

A close-up photograph of a man and a woman smiling warmly at the camera. The woman is on the left, with long brown hair, and the man is on the right, with dark curly hair. They are both wearing pink and white striped shirts. The background is a soft-focus green, suggesting an outdoor setting.

Give yourself every advantage... Good health and a bright smile.

Regular dental check-ups and cleanings are important to your overall health. That's why we give you the option of adding dental to your health coverage or even purchasing a dental plan on its own.

We've got you covered

To help keep your smile bright and healthy, we've put together dental products that offer a broad range of benefits. And then we made it affordable.

- Diagnostic and preventive services — 100% covered when using a network dentist
- Routine checkups and cleanings
- X-rays and fluoride applications
- Fillings, space maintainers and sealants
- Scaling/root planning, root canals, crowns and dentures covered in some dental plans.

Plus, Anthem dental members automatically have access to the International Emergency Dental Program administered by DeCare Dental. With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world

Additional Savings

With Anthem dental plans, you also get discounts on non-covered dental services like teeth whitening and orthodontia, and provider discounts after you meet your annual maximum.

Please contact your agent or visit us online at anthem.com to get additional details on Anthem's dental plans, get a quote or enroll.

This is only a summary of Anthem dental benefits. For complete benefit details, please refer to your Individual Dental Policy.

The International Emergency Dental Program is administered by DeCare Dental. DeCare Dental is an independent company offering dental administrative services to Anthem Blue Cross and Blue Shield plans.

Save money and time by using our dental network

While our dental PPO plans allow you to go to any dentist, you may save the most money when you choose one of the dentists in our PPO provider network. Even better, when you visit a network dentist, you have no deductible or coinsurance to pay for any covered diagnostic or preventive service. And network dentists file claims so there is no paperwork for you to do when you receive services.

Optional Term Life Insurance

You can add Anthem Blue Preferred® Term Life Insurance to your health coverage. It's easy. There are no medical exams or extra forms to fill out. Simply use your application to apply for coverage.

Term Life Monthly Rates

Age	\$15,000	\$25,000	\$50,000
1-18	\$1.50	\$2.50	N/A
19-29	\$2.85	\$4.75	\$9.50
30-39	\$3.30	\$5.50	\$11.00
40-49	\$7.50	\$12.50	\$25.00
50-59	\$20.85	\$34.75	\$69.50
60-64	\$29.40	\$49.00	\$98.00

Additional information

Save time with automatic premium payments

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.

Ready to choose a plan?

- **Call us.** Contact your Anthem Blue Cross and Blue Shield agent.
- **Ask questions.** If you aren't sure about how a plan works or have additional questions, your agent will be happy to help.
- **Fill out an application.** We'll process it as soon as we receive it!

Individual health coverage. Your plans. Your choices.

Make sure you have all the facts.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan[s] described — including what's covered, and what isn't. For additional information about exclusions, limitations, and terms of this coverage, please see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this brochure from your computer, it should be at the end. If you did not receive a copy of the Coverage Details, be sure to contact your Anthem agent.

This brochure is intended as a brief summary of benefits and services; it is not your Contract/Certificate of Coverage. If there is any difference between this brochure and your Contract/Certificate of Coverage, the provisions of the Contract/Certificate of Coverage will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

We want you to be satisfied.

If you aren't satisfied with your 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.

Ready to enroll?

Call your Anthem agent today!

Stay focused on your fitness.



Let ACS | BNY Mellon handle the finances.

YOU'RE ONLY ONE CHECKMARK AWAY

Simply make the selection on your application form. We'll take care of setting up your account. We'll also take care of sending you a Welcome Kit to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

Setting up a Health Savings Account

Our Lumenos® HSA plans are a nice way to save on premiums. But that's just the tip of the savings iceberg. To realize your plan's full financial power, consider opening a health savings account to go with your Lumenos plan. The portability and tax savings of an HSA account can add up fast.

We've joined with Affiliated Computer Services (ACS) and The Bank of New York Mellon (BNY Mellon) to integrate their HSA accounts with our Lumenos HSA plans. Setting up your account with BNY Mellon is easy. Plus, it comes with built-in advantages and conveniences:

- A single customer service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including special checks and automatic fund transfers
- Competitive interest rates and investment opportunities for the funds in your account

Of course, if you'd rather use another financial institution for your account, that's fine too.

A closer look

HSA Welcome Kit

If you make the selection on your application form, your Health Savings Account will automatically be set up once you're approved for the Lumenos HSA plan, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using your account. A separate application for your account is only required if you choose a financial institution other than BNY Mellon.

This is what the IRS requires if you want to open a Health Savings Account:

- You must be covered by an HSA-compatible high deductible health plan (such as the Lumenos HSA plan).
- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.
- You cannot be covered by any other medical plan that is not an HSA-compatible high deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on another individual's tax return.
- If you are a veteran, you may not have received veteran's benefits within the last three months.
- You cannot be active military.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum \$1,500 HSA balance. Investment options include a number of mutual families. Once you're ready to invest, just call the ACS | BNY Mellon HSA Solution Contact Center at 866-686-4798 Monday through Friday from 8 a.m. to 8 p.m. (Eastern Time) for a prospectus with more details.

Debit cards and checkbooks

Use your MasterCard® debit card or your HSA checkbook (provided by BNY Mellon) to pay your health care provider or pharmacy directly for eligible medical expenses, or to get cash from your account.

Deposits to your account

To contribute to your HSA, simply send a check and deposit slip to the address printed on your HSA checkbook. Or you can set up an electronic funds transfer between your bank and BNY Mellon for regular account contributions.

Account activity statement

Each month, you'll receive a statement from BNY Mellon that shows all of your account activity. For an additional fee of \$0.75 per month, you can receive a paper statement. Please go to Anthem.com or call your dedicated Customer Service to learn how to elect this option. You'll also receive IRS 1099 and IRS 5498 forms from BNY Mellon near tax time to help with tax preparation.

ACS | BNY Mellon HSA fee and rate schedule

A Deposit Agreement and a Disclosures and Fee Sheet will be in your HSA Welcome Kit. Please refer to those documents for the complete terms and conditions related to your account.

As good as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Administrative fees	
One time account set-up	\$15
Banking fees	
Monthly account fee	\$2.95
Debit card transactions	no charge
Check writing	no charge
ATM transactions	\$1
Card replacement	\$5
Check reorder	\$10
Non-sufficient funds	\$25
Stop check service	\$25
Duplicate check	\$5
Periodic paper statement	\$0.75

ACS | BNY Mellon is an independent corporate entity that provides banking administration on behalf of Anthem Health Plans, Inc., d/b/a Anthem Blue Cross and Blue Shield. Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; CompCare 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 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 the registered marks of the Blue Cross and Blue Shield Association.

Ohio Coverage Details

Things you need to know before you buy...

SmartSense[®], CoreShareSM and Lumenos[®] HSA

Before choosing a health care plan, please review the following information, along with the other materials enclosed.

Who Can Apply?

You can apply for coverage for yourself or with your family. You must be a resident of Ohio, under the age of 65, not eligible for Medicare and a legal resident of the U.S. 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 age 28.

What's A Pre-Existing Condition?

For applicants age nineteen and older, our policies cover pre-existing conditions after you've been enrolled in the plan for 12 months. A pre-existing 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 “pre-existing”. The pre-existing condition limitation does not apply to applicants under the age nineteen.

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.

Access to the Medical Information Bureau (MIB)

Information regarding your insurability will be treated as confidential. Anthem Blue Cross and Blue Shield or its reinsurers may, however, make a brief report thereon to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is:
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Information for consumers about MIB may be obtained on its website at www.mib.com. Anthem Blue Cross and Blue Shield, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional

licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review / Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What Our Individual Health Care Plans Do Not Cover

The following Exclusions and Limitations will help you understand what your health care plan does not include before you enroll. These are just some of the plans' limitations and exclusions. Check your Contract or Certificate of Coverage for a complete listing of benefits, exclusions and maximum payment levels.

Medical Exclusions And Limitations

Our plans do not provide benefits for:

- Services, supplies or charges having to do with pre-existing conditions (see "What's A Pre-Existing Condition?")
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Private duty nursing
- Maternity services, unless an optional maternity rider is purchased
- Experimental or investigative treatment
- Dental and vision, except as spelled out in your Contract
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Services covered by Medicare or a governmental program
- Care provided by a member of your family
- Educational services
- Comfort and/or convenience items
- 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
- Sclerotherapy
- Routine foot care
- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Sex transformation surgery
- Custodial care
- Artificial and mechanical hearts
- Workers' compensation
- Specialty drugs purchased at non-network pharmacies
- Over-the-counter drugs, devices or products
- TMJ and Craniomandibular Joint Disorders
- Services we determine aren't medically necessary

In addition our **SmartSense, CoreShare and Lumenos HSA** plans also limit the following outpatient services to 20 visits combined network and non-network:

- Speech therapy
- Physical therapy and/or manipulation therapy
- Occupational therapy

Other limitations of our plans include:

- Home health care services limited to 60 visits
- Optional maternity rider subject to a 270-day waiting period (Maternity rider not available on SmartSense, Lumenos HSA, or CoreShare)
- Outpatient Psychiatric Care and Outpatient Substance Abuse Services are subject to a combined limit of 10 visits per benefit period.
- Inpatient Psychiatric Care and Inpatient Substance Abuse Services are subject to a combined limit of 10 days per benefit period.

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 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 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 members.

We Want You To Be Satisfied

If you aren't satisfied with your 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.

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 document and your Contract or Certificate of Coverage, the terms of your Contract or Certificate of Coverage will prevail. Read your Contract or Certificate of Coverage carefully. Anthem has the right to rescind, cancel, terminate or reform your coverage based on provisions described in the Contract or Certificate of Coverage.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Guide, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Blue Cross and Blue Shield agent to request them.