



**Be part of
the solution.**

**Helping your employees do the
best things for their health.**

Anthem 
Health. Join In.™



A health plan that's part of the solution

Reigning in the high cost of health care — it's a top priority for many, and understandably so. But, what if you could offer a lower premium, higher-deductible health plan that actually gives your employees more of what they need to be their healthiest? That's what Anthem's Lumenos plans are designed to do.

Anthem's Lumenos plans put your employees in control of their health care decisions. By offering information and motivation, these plans can help them get the most health care from their health care dollars. This is not a temporary fix. This is a solution that can help keep your employees — as well as your company — healthier in the long run.

Ground-breaking plans from a well-grounded company

These plans are setting the pace in the industry with progressive plan designs, technology and service. Combine this with the stability and strength of Anthem Blue Cross and Blue Shield, and you have a powerful combination that's both innovative and established.

Plan designs that encourage better health

Each consumer-driven health plan starts with a health account that helps pay for covered medical services and prescriptions, up to 100% coverage for covered preventive care services, and traditional health coverage to protect your employees from potential large out-of-pocket expenses. That's just for starters. Anthem's Lumenos plans also come with a wide variety of health tools and programs, so employees can do the best things for their health. You can also offer incentives — called rewards — when your employees adopt healthy behaviors.

A network that gives employees access to more doctors and hospitals

Through the Blue Cross and Blue Shield Association's BlueCard® program, your employees have access to more than 90% of hospitals and 80% of physicians, across the country. They also have access to providers around the world through the BlueCard Worldwide® program. Being part of such a large network allows Anthem to negotiate attractive discounts with providers. This can lead to significant savings for employees who use network providers, which means they can stretch their health care dollars even further.

Customer service that focuses on meeting your needs

Everything Anthem does focuses on delivering a superior experience to you and your employees. Whether it's answering a question on coverage or resolving an issue quickly, the goal is to meet you and your employees' needs efficiently and correctly the first time.

Integrated plans that put information in your employees' hands

The systems that support Anthem's Lumenos plans are integrated to provide more efficient service. From account information to prescription benefits, almost every aspect of the plan is connected, so claims are processed correctly in a timely manner. This integrated system has another advantage: It helps put information right in your employees' hands when they register at anthem.com. They also receive their claims recap and monthly statement by mail. So your employees always have access to the information they need, when they need it.

Financial stability that can weather tough economic times

Even in challenging economic times, you can feel confident that Anthem's Lumenos plans are backed by financial strength. Anthem has consistently earned high marks from rating agencies for its financial strength and ability to pay claims.

A health plan that's different, yet familiar

Anthem's Lumenos plans are different. For one thing, each is coupled with a health account, which may be a new concept for your employees. But these plans look familiar, too. That's because they all include traditional coverage your employees can count on. Here's how Anthem's Lumenos plans work:

- *First, a health account helps pay for covered medical services**. The health account works much like a bank account. Employees use its funds to pay for covered medical services and to help satisfy the deductible. Unused funds roll over from year to year.**
- *Plus, preventive care helps employees stay their healthiest*. The plan pays up to 100% for nationally recommended preventive care received from network providers. There are no funds taken from the health account, and there are no additional out-of-pocket costs.
- *Then, traditional health coverage kicks in*. After meeting the annual deductible, your employees use their traditional health coverage to protect them from large health expenses. An annual out-of-pocket maximum limits the amount your employees pay during the plan year.

* Deductible First HRA requires that the upfront deductible is satisfied before HRA dollars are available to pay for medical and prescription expenses.

** Rollover benefit vary based on plan design selected.

OUR MEMBERS USE PREVENTIVE CARE BENEFITS

Consumer-driven health plan members take advantage of their preventive care benefits more than standard PPO members.¹ Preventive care can help detect a health concern before it becomes a health problem, which can lead to better health and long-term savings.

Questions about your options?
Contact your broker or
Anthem sales representative
for more details.

Plan options

Whether your employees are new to consumer-driven health care or they're already pros, there's an Anthem's Lumenos plan that's right for your company.

Health Savings Account (HSA) compatible plans

The HSA-compatible plan offers maximum cost effectiveness. Employees make pre-tax contributions to their accounts. Your company can contribute, too. You can even offer rewards for healthy behaviors. The funds do not have to be used for first dollar coverage, so your employees choose when to use them. Plus, unused funds roll over from year to year. Through a partnership with a financial institution, we integrate the financial and health administration of the plan, so you and your employees have a single point of contact for almost every aspect of the plan.

Health Reimbursement Account (HRA) plans

With an HRA, your company makes upfront contributions to the health accounts. These funds are always used for first dollar coverage. If the health account runs out, employees are responsible for the rest of the deductible. Unused HRA dollars roll over to the next year,** giving them even more money for the next plan year, which can help reduce potential out-of-pocket expenses. Plus, employees can earn additional funds for their account with rewards for healthy behaviors.

Health Incentive Account Plus (HIA Plus) plans

This plan works just like an HRA. Your employees receive annual allocations to their health accounts. These funds offer first dollar coverage, and unused funds roll over from year to year,** which can help reduce potential out-of-pocket expenses. Plus, your employees can earn additional dollars for taking steps to improve their health. The only difference with this plan: Anthem funds the health accounts.

Health Incentive Account (HIA) plans

An HIA can help you introduce the idea of consumer-driven health care to your employees. The health accounts are solely funded by rewards your employees earn when they do things like quitting smoking or managing their weight. Like HRA plans, funds offer first dollar coverage and roll over if not used. Contributions are made by either your company or by Anthem.

Deductible First HRA plans²

This HRA includes one unique component: an upfront deductible. This means your employees must satisfy a portion of their deductible before they can access the funds in their accounts. Like a typical HRA, unused dollars roll over to the next year** and employees can earn rewards for healthy behaviors.

** Rollover benefit vary based on plan design selected.

	HSA-compatible	HRA & Deductible First HRA ²	HIA Plus ²	HIA ²
What are the group size requirements?	None	Varies by state ³	None	None
What are the funding options?	Medical: ASO or Fully Insured Rewards: ⁴ ASO or Fully Insured	Medical: ASO or Fully Insured Rewards: ASO or Fully Insured	Medical: Fully Insured Rewards: Fully Insured	Medical: ASO or Fully Insured Rewards: ASO or Fully Insured
What's the account type?	Cash	Notional	Notional	Notional
Who can make contributions?	Employer, Employee or both	Employer	Health plan	Employer or Health plan
How often can contributions be made?	At any time	Annual allocation ⁵	Annual allocation ⁵	As incentives are earned
Who funds the health incentives?	Employer or Health plan ⁴	Employer	Health plan	Employer or Health plan
Is the account portable?	Yes	No	No	No
Do funds roll over?	Yes, no maximum	Yes, rollover options vary by plan availability; contact your broker or sales rep for plan availability	Yes, rollover options vary by plan availability; contact your broker or sales rep for plan availability	Yes, no maximum
How can account funds be used?	Funds used for all qualified medical expenses, as defined by IRS [Sec. 213(d)]	Funds used for services covered by the health plan that are applied to deductible or coinsurance	Same as HRA	Same as HRA
How are payments made?	Made from the account by the member, and with the debit card and/or check	Automatically deducted from the account	Automatically deducted from the account	Automatically deducted from the account
Can an employee also have an FSA?	Yes, a Limited Purpose FSA may be used for dental and vision; and/or a Limited Purpose High Deductible FSA may be used for dental or vision plus coinsurance after deductible has been met (employer must be able to administer); pays as secondary	Yes, pays as secondary	Yes, pays as secondary	Yes, pays as secondary
Is this subject to COBRA?	No, members keep the dollars in the account, even if they leave the plan	Yes	Yes	Yes

OUR MEMBERS ARE EMBRACING HEALTHY BEHAVIORS

Since enrolling in consumer-driven health plans, our members are more likely to use network providers, receive preventive care and do their homework before making a health decision.⁷ Our support tools and programs can help members with these healthy and money-saving behaviors.

More plan features

A health plan that's packed with more health

Compared to those with standard health plans, consumer-driven health plan members are more likely to look for ways to manage their health and health care spending.⁶ Through 360° Health®, your employees have the resources they need to do this. They can tap into a variety of support tools and programs that offer:

Tools and resources — because there's no such thing as too much information


- **Online account management:** Members go to anthem.com to see their account balances, view claims and find prices for prescriptions drugs.
- **Online provider directory:** Members go online to find network doctors, hospitals, pharmacies and other health care professionals.
- **Healthy discounts:** Members get money-saving discounts of up to 50% on health-related products and services including health clubs, frames and lenses, maternity must-haves and alternative therapies.
- **24/7 NurseLine:** This toll-free telephone services allows members to talk with a registered nurse when they have general health questions or need guidance with critical health concerns.

Personal guidance — recruiting the help of a health expert and earning health rewards for doing it

- **Health coaching programs:** Members work with a personal nurse or health coach who can help them manage their high blood pressure, high cholesterol, lower back pain, and more.
- **Healthy Lifestyles programs:** Tobacco cessation and weight management programs help employees adopt healthy lifestyles with personalized support and educational resources.
- **Future Moms:** Expecting moms can get education and information that can help them get their pregnancies — and babies — off to healthy starts. Extra help is available for high-risk pregnancies.

Condition management — tackling chronic conditions with individualized support

- **ConditionCare.** Members get help managing chronic conditions, such as asthma, diabetes, heart failure, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD).
- **ComplexCare.** Members dealing with complex health issues, such as having multiple health conditions, receive personalized support so they can better manage their health.



A health plan that works for everyone

You may think that saving money means offering the most basic benefits or even cutting benefits altogether. But there is an alternative. With Anthem's Lumenos plans, you can control your costs, while giving your employees a plan that goes well beyond basic coverage. You can offer a plan that helps them make the best decisions for their health. The results could be healthier people who are getting the most from their health care dollars. It's a long-term solution that works for you and your employees.

Consumer-driven health plans work best when your company provides ongoing support and encouragement. We are here to help you with this every step of the way.

Better health can be an employee's greatest reward. Of course, extra incentives can help, too.

With Anthem's Lumenos plan, you can offer rewards that encourage healthy behaviors. Your employees can earn these rewards when they:

- Complete the MyHealth Assessment
- Enroll in a health coaching program
- Graduate from a health coaching program
- Complete a Healthy Lifestyles program
- Enroll in a ConditionCare program

QUESTIONS ABOUT YOUR OPTIONS?

Contact your broker or Anthem sales representative for more details.



¹ Lumenos Experience Analysis: Impact on CDH on Member Utilization Patterns, Sept. 2008.
² May not be available in all markets; contact your broker or sales representative for plan availability.
³ Requirements subject to change; please confirm group eligibility with your broker or sales representative.
⁴ Incentives/rewards not available with HSA-compatible plans in local group California, Colorado and Nevada.
⁵ Proration options available for HRA and HIA Plus plans.
⁶ The 2008 EBRI Consumer Engagement in Health, http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=4110
⁷ WellPoint Member Engagement Survey, 2008.

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Lumenos® with HSA and Rewards Plan Summary

The Lumenos with HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you the benefits you would receive from a typical health plan, plus health care dollars to spend your way. And you can earn rewards for taking certain steps to improve your health.

Your Lumenos with HSA and Gift Card Rewards Plan

First - Use your HSA to pay for covered services:

Health Savings Account

With the Lumenos with Health Savings Account (HSA), you can contribute pre-tax dollars to your HSA. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

Contributions to Your HSA

For 2011, contributions can be made to your HSA up to the following:

- \$3,050 individual coverage
- \$6,150 family coverage

Note: These limits apply to all combined contributions from any source including HSA dollars from rewards. Rollover funds are not subject to these limits.

Plus - To help you stay healthy, use:

Preventive Care

100% coverage for nationally recommended services.

Preventive Care

No out-of-pocket costs for you as long as you receive your preventive care from a network provider. If you choose to go to an out-of-network provider, your deductible or traditional health coverage benefits will apply.

Then -

Your Deductible

The deductible is the annual amount you pay – using your HSA or out-of-pocket – before you reach the traditional health coverage portion of the plan.

Annual Deductible Responsibility

- \$1,500 individual coverage
- \$3,000 family coverage

Your benefit period may be a calendar year or a plan year. A calendar year means your benefit period runs from January through December while a plan year runs from the effective date of the plan through a 12-month period (e.g. February 1 through January 31 or July 1 through June 30).

If needed -

Traditional Health Coverage

Similar to a PPO or HMO, after you meet your deductible, you pay coinsurance (a percentage of the provider's charges) or a copay when you visit a network provider. You'll pay more if you visit an out-of-network provider.

¹Plan pays percentage after member tier copay/coinsurance.

²For tier 3 drugs, copay or coinsurance whichever is greater up to \$200 per script retail and \$400 per script mail.

Traditional Health Coverage

After your deductible, the plan pays:

- | | |
|--|---|
| 100% for network providers | 70% for out-of-network providers |
| 100% for network pharmacies ¹ | same as network pharmacies ¹ |

After your deductible, your coinsurance or copay responsibility is:

- | | |
|--|----------------------------------|
| 0% for network providers | 30% for out-of-network providers |
| Retail ² : \$10/\$30/\$50 or 20% for network pharmacies | same as network pharmacies |
| Mail ² : \$10/\$60/\$150 or 20% for 90-day supply | n/a |

Additional protection:

For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the plan pays 100% of the cost for covered services for the remainder of the plan year.

Annual Out-of-Pocket Maximum

- | | |
|-----------------------------|-----------------------------|
| Network Providers | Out-of-Network Providers |
| \$2,500 individual coverage | \$3,000 individual coverage |
| \$5,000 family coverage | \$6,000 family coverage |

Your annual out-of-pocket maximum consists of your annual deductible and your copay/coinsurance amounts.

Earn More Money for Your Account

What's special about your HSA plan is that you may earn rewards dollars to redeem for gift cards to select retailers. It's how your Lumenos plan rewards you for taking steps to improve your health.

Earn Rewards:

- | | |
|---|--|
| If you do this: | You can earn these rewards dollars for gift cards: |
| Complete the MyHealth Assessment online | \$50 |
| Enroll in a Health Coaching Program | \$100 |
| Graduate from a Health Coaching Program | \$200 |
| Complete our Healthy Lifestyles: Tobacco-Free Program | \$50 |
| Complete our Healthy Lifestyles: Healthy Weight Program | \$50 |

Lumenos with HSA and Rewards Plan Summary

Overview of Covered Preventive Services

Preventive Care

Anthem's Lumenos with HSA plan covers 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 to help prevent avoidable premature injury, illness and death.

All preventive services received from a network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes — for example, a colonoscopy when symptoms are present — the appropriate plan deductible and coinsurance will apply and available account funds may be used to cover costs.

The following is an overview of the types of preventive services covered:

Child Preventive Care

Office Visits for preventive services

Screening Tests for vision, hearing, and lead exposure. Also includes pelvic exam and Pap test for females who are age 18, or have been sexually active.

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer
- H. Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)

Adult Preventive Care

Office Visits for preventive services

Screening Tests for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams and Pap test.

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer

Summary of Exclusions or Limitations

Some covered services may have limitations or other restrictions.* With Anthem's Lumenos with HSA plan, the following services are limited:

- Annual routine vision exam \$15; not subject to deductible.
- Skilled nursing facility services limited to 100 days per benefit period.
- Home health care services limited to 90 visits per benefit period.
- Early intervention limited to \$5,000 per benefit period.
- Physical and occupational therapy services limited to a combined 30 visits per benefit period.
- Speech therapy services limited to 30 visits per benefit period.
- Spinal manipulations and other manual medical intervention visits limited to 30 visits per benefit period.
- Durable medical equipment benefit is **unlimited**.
- Private duty nursing limited to \$500 per benefit period maximum.
- Wigs limited to \$500 per benefit period maximum.
- Your Lumenos with HSA also includes **No Lifetime Maximum**.

*Additional limitations and exclusions may apply. For a complete list of exclusions and limitations, please refer to your Certificate of Coverage. Some covered services may require pre-approval.

Please note: This summary 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 Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail. This summary is for a full year in the Lumenos plan. If you join the plan mid-year or have a qualified change of status, your actual benefit levels may vary. The information included does not constitute legal, tax, or benefit plan design advice. Anthem strongly encourages consultation with a tax advisor before establishing a Health Savings Account. Any Health Savings Account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

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The Ins and Outs of Coverage

Knowing that you have health care coverage that helps meet your and your family's needs is reassuring. But part of your decision in choosing a plan also requires understanding:

- who can be enrolled
- how coverage changes are handled
- what's not covered by your plan
- how your plan works with other coverage

Who Can Be Enrolled

You can choose coverage for you alone or family coverage that includes you, your spouse and your qualified* dependents.

**as determined by the Patient Protection and Affordable Care Act*

Dependent children are covered until the end of the month in which they turn 26.

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they reached age 26.

How Coverage Changes Are Handled

Your Lumenos coverage can be renewed, cancelled or changed on two different levels. The first is on the employer level, which would impact you and everyone else covered under your employer's plan. The second level impacts your coverage only — including your covered family members — and does not apply to any others covered under your employer's plan.

The Ins and Outs of Coverage (continued)

1. On the employer level – which impacts you as well as all employees under your employer's plan – your Lumenos plan can be ...

renewed	cancelled	changed	when...
•			your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	•		your employer makes a bad payment, voluntarily cancels coverage (30-day advance written notice required), is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan, or still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	•		we decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		•	your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Lumenos coverage.

2. On an individual level – factors that apply to you and covered family members – your Lumenos plan can be...

renewed	cancelled	when...
•		you maintain your eligibility for coverage with your employer, pay your required portion of the health care premium and do not commit fraud or misrepresent yourself.
	•	you purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	•	you lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card or file false claims with us. Your coverage will be cancelled after you receive a written notice from us.

The Ins and Outs of Coverage (continued)

Special Enrollment Periods

Typically you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is first offered to you as a "new hire" or during your employer's open enrollment period when employees can make changes to their benefits for an upcoming year. But there may be instances other than these situations in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage. But, you must ask to be enrolled within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents' coverage under Medicaid or the state Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

About Pre-Existing Conditions

Have you been treated for or diagnosed as having a specific condition other than pregnancy? If you have been, did the diagnosis or treatment occur less than 6 months before the date you will begin coverage under your employer's group health plan or by the start of the waiting period required by your employer, whichever is earlier? If so, there is a 12-month period when services may* not be covered for those specific conditions — often called "pre-existing conditions." All other covered services not related to the pre-existing conditions will be available beginning on your first day as a Lumenos member. If you or a covered family member have had breast cancer and have been disease-free for five years, it is not considered a pre-existing condition, even if you have had routine follow-up visits to monitor for recurrence within the past 6 months or during your employer's required waiting period.

* Your 12-month pre-existing period can be reduced by the number of months of "creditable coverage" you had before your group health plan coverage (or employer-required waiting period) starts. Creditable coverage is earned by having had coverage under most types of group or individual: health insurance programs

- HMO plans
- health service plans
- fraternal society plans, or
- publicly-sponsored plans like Medicare, Medicaid, State Children's Health Insurance Program (S-CHIP) or TRICARE

The Ins and Outs of Coverage (continued)

You should receive proof of prior coverage (called a “certificate of creditable coverage”) from either the employer with whom you had the coverage or the health care company that provided it. If you go more than 63 days without health care coverage, coverage before that 63-day break will not reduce your pre-existing period. So that we may reduce the pre-existing period by the amount of time you were covered under creditable coverage, we may require you to give us a copy of any certificates of creditable coverage that you have. If you do not have a certificate, but you have creditable coverage, we will help you get one from your prior plan or issuer. Contact Member Services either by phone or by the address listed on the back of this enrollment brochure.

How We Establish Our Rates

Factors used to set the price of health care coverage for employers with 2-99 employees:

- the Lumenos plan selected by your employer
- your employer's location
- the age and gender of each employee
- the number of enrolled employees
- the number of dependents enrolled by each employee
- the health status of the enrolled employees and their dependents

Additional factors for employers with 15-99 employees:

- your employer's industry

When You're Covered by Multiple Plans

If you're fortunate enough to be covered by more than one health plan, you may not be so thrilled about the paperwork hassles that can come with it when you're trying to figure out which plan should pay for what. Our Coordination of Benefits (COB) program helps ensure that you receive the benefits due and avoid overpayment by either carrier. Because up-to-date, accurate information is the key to our Coordination of Benefits program, you can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

If you are covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay a claim and provide reimbursement according to plan allowances; the secondary carrier then provides reimbursement, typically covering the remaining allowable expenses.

The Ins and Outs of Coverage (continued)

Determining the primary versus secondary carrier

See the chart below for how determination gets made over which health plan is the primary carrier. The term “participant” is used and means the person who is signing up for coverage:

When a person is covered by 2 group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	•	
	The plan with COB is		•
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	•	
	The plan covering the person as a dependent is		•
The person is the participant in two active group plans	The plan that has been in effect longer is	•	
	The plan that has been in effect the shorter amount of time is		•
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	•	
	The COBRA plan is		•
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	•	
	The plan of the parent whose birthday is later in the calendar year is		•
	Note: When the parents have the same birthday, the plan that has been in effect longer is	•	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	•	
	The plan of the other parent is		•
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	•	
	The non-custodial parent's plan is		•
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	•	
	The plan of the parent whose birthday is later in the calendar year is		•
	Note: When the parents have the same birthday, the plan that has been in effect longer is	•	

The Ins and Outs of Coverage (continued)

How Benefits Apply When Medicare-Eligible

Some people under age 65 are eligible for Medicare in addition to any other coverage they may have. The following chart shows how payment is coordinated under various scenarios:

renewed	cancelled	changed	when...
Is a person who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	•	
	Upon completion of the 30-month Medicare entitlement period		•
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	•	
	If the group plan has fewer than 100 participants		•
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	•	
	If the group plan has fewer than 100 participants		•
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	•	
	If Medicare had been primary to the group plan before ESRD entitlement		•

Recovery of overpayments

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover any overpayment from:

- any person to or for whom the overpayments were made;
- any health care company; and
- any other organization.

The Ins and Outs of Coverage (continued)

What's Not Covered (Exclusions)

When it comes to your health, you're the final decision maker about what services you need to get and where you should get them. But, in order for us to keep the cost of health care as low as possible for both you and your employer, we have to exclude certain services. The following list of services and supplies are excluded from coverage by your health plan and will not be covered in any case.

acupuncture

biofeedback therapy

over-the-counter **convenience** and hygienic items including, but not limited to, adhesive removers, cleansers, underpads, and ice bags

cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to help improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

dental services except: medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem.

- cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth
- repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face
- dental services and appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer
- covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.

donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood-related family members (parent, child, sibling)

These services are not covered by your Lumenos plan.

The Ins and Outs of Coverage (continued)

EXPERIMENTAL ... OR NOT?

Many of the Anthem medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage. To be approved for coverage, the service or product must have:

- regulatory approval from the Food and Drug Administration;
- been put through extensive research study to find all the benefits and possible harms of the technology;
- benefits that are far better than any potential risks;
- at least the same or better effectiveness as any similar service or procedure already available; and
- been tested enough so that we can be certain it will result in positive results when used in real cases.

experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. This will not prevent a member from being able to appeal Anthem's decision that a service is not experimental/investigative.

family planning

- any services or supplies provided to a person not covered that is in connection with a surrogate pregnancy, including but not limited to, the bearing of a child by another woman for an infertile couple
- services to reverse voluntarily induced sterility
- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures
- drugs used to treat infertility

services for palliative or cosmetic **foot care**

- flat foot conditions
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- foot orthotics
- subluxations of the foot
- corns
- bunions (except capsular or bone surgery)
- calluses
- care of toenails
- fallen arches
- weak feet
- chronic foot strain
- symptomatic complaints of the feet

health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

hearing care except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

These services are not covered by your Lumenos plan.

The Ins and Outs of Coverage (continued)

home care services

- homemaker services
- maintenance therapy
- food and home delivered meals
- custodial care and services

hospital services

- guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay
- care by interns, residents, house physicians, or other facility employees that are billed separately from the facility
- a private room unless it is medically necessary

maternity benefits for your dependent children

medical equipment, appliances and devices, and medical supplies that have both a nontherapeutic and therapeutic use:

- exercise equipment
- air conditioners, dehumidifiers, humidifiers, and purifiers
- hypoallergenic bed linens
- whirlpool baths
- handrails, ramps, elevators, and stair glides
- telephones
- adjustments made to a vehicle
- foot orthotics
- changes made to a home or place of business
- repair or replacement of equipment you lose or damage through neglect

medical equipment (durable) that is not appropriate for use in the home

services or supplies deemed **not medically necessary** as determined by Anthem at its sole discretion. This will not prevent a member from being able to appeal Anthem's decision that a service is not medically necessary.

The following exceptions qualify for coverage.

For inpatients:

1. services rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians or related outpatient services or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services

These services are not covered by your Lumenos plan.

The Ins and Outs of Coverage (continued)

2. services rendered by your attending provider other than inpatient evaluation and management services. Inpatient evaluation and management services include routine visits by your attending provider to review patient status, test results, and patient medical records and do not include surgical, diagnostic, or therapeutic services.

For outpatients:

services of pathologists, radiologists and anesthesiologists rendering services in an (i) outpatient hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. This exception does not apply if and when pathologist, radiologist or anesthesiologist assumes the role of attending physician.

mental health and substance abuse

- inpatient stays for environmental changes
- cognitive rehabilitation therapy
- educational therapy
- vocational and recreational activities
- coma stimulation therapy
- services for sexual deviation and dysfunction
- treatment of social maladjustment without signs of a psychiatric disorder
- remedial or special education services
- inpatient mental health treatments that meet the following criteria:
 - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital
 - group psychotherapy when there are more than 8 patients with a single therapist
 - group psychotherapy when there are more than 12 patients with two therapists
 - more than 12 convulsive therapy treatments during a single admission
 - psychotherapy provided on the same day of convulsive therapy

nutrition counseling and related services, except when provided as part of diabetes education or when received as part of a covered wellness services visit or screening.

nutritional and/or dietary supplements, except as specifically listed in this enrollment brochure or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

obesity services and supplies related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered

These services are not covered by your Lumenos plan.

The Ins and Outs of Coverage (continued)

services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

paternity testing

prescription drug benefits

- over-the-counter drugs
- any per unit, per month quantity over the plan's limit
- drugs used mainly for cosmetic purposes
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the maximum allowed amount for that prescription
- drugs for weight loss
- stop smoking aids
- therapeutic devices or appliances
- injectable prescription drugs that are supplied by a provider other than a pharmacy
- charges to inject or administer drugs
- drugs not dispensed by a licensed pharmacy
- drugs not prescribed by a licensed provider
- any refill dispensed after one year from the date of the original prescription order
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies
- medicine furnished by any other drug or medical service
- medications used to treat sexual dysfunction (only applicable for groups who have selected a Generic Premium Option drug plan)

private duty nurses in the inpatient setting

rest cures, custodial, residential or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic service.

These services are not covered by your Lumenos plan.

The Ins and Outs of Coverage (continued)

care from **residential treatment centers** or other non-skilled inpatient settings, except to the extent such setting qualified as a substance abuse treatment facility licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care

services or supplies

- ordered by a doctor whose services are not covered under your health plan
- are of any type given along with the services of an attending provider whose services are not covered
- not listed as covered under your health plan
- not prescribed, performed, or directed by a provider licensed to do so
- received before the effective date or after a covered person's coverage ends
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms

services or supplies

- for travel, whether or not recommended by a physician
- given by a member of the covered person's immediate family
- provided under federal, state, or local laws and regulations including Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted.
- provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government
- received from an employer mutual association, trust, or a labor union's dental or medical department
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities

services for which a charge is not usually made including those services for which you would not have been charged if you did not have health care coverage

services or benefits for:

- amounts above the allowable charge for a service
- self-administered services or self care
- self-help training
- biofeedback, neurofeedback, and related diagnostic tests

These services are not covered by your Lumenos plan.

The Ins and Outs of Coverage (continued)

services or supplies primarily for educational, vocational, or self management/training purposes, except as otherwise specified in the Enrollment booklet or when received as part of a covered wellness services visit or screening

sexual dysfunction surgery or sex transformation services, including medical and mental health services

skilled nursing facility stays

- treatment of psychiatric conditions and senile deterioration
- facility services during a temporary leave of absence from the facility
- a private room unless it is medically necessary

smoking cessation programs not affiliated with us

spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions

telemedicine

- non-interactive telemedicine services, including an audio-only telephone conversation, electronic mail message or facsimile transmission

therapies

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services
- group speech therapy
- group or individual exercise classes or personal training sessions
- recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy

vision services

- vision services or supplies unless needed due to eye surgery and accidental injury
- routine vision care and materials
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure
- services for vision training and orthoptics
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury
- sunglasses or safety glasses and accompanying frames of any type
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- any lost or broken lenses or frames

These services are not covered by your Lumenos plan.

The Ins and Outs of Coverage (continued)

- any blended lenses (no line), oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, anti-reflective coating, cosmetic lenses or processes, or UV-protected lenses
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- any other vision services not specifically listed as covered

weight loss programs whether or not they are pursued under medical or physician supervision, unless specifically listed as covered. This exclusion includes, but is not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

The most detailed description of benefits, exclusions and restrictions can be found in the following group policies and certificate booklets which can be requested by calling a Customer Service representative at 1-800-582-6941:

PP-INTRO (10/10), P-TOC (7/10), P-SB5 (10/10), P-WORKS (10/10), P-COVERED (10/10), P-EXCL (10/10), P-CLAIMS (10/10), P-COB (7/10), P-ENR (10/10), P-ENDS (10/10), P-INFO (10/07), P-RIGHTS (7/09), P-DEF (10/10), P-EXH-A (1/10), P-INDEX (7/10), P-ACC (7/10), GP-1 (7/02), GP-TOC, GP-ELIG (7/07), GP-1-GEN (10/10)

Enrollment applications used for Anthem's Lumenos plans:

490760 (7/10), 490773 (7/10), 490750 (4/03), 490751 (4/03), 490752 (4/03), 490753 (8/03), 490756 (4/03), AVA1143, AVA1144, AVA1145 (9/04), AVA1146, 111578 (3/07)

This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem Lumenos plans offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area.

For more information, please call a Customer Service representative at 800-582-6941 or visit us on the Web at anthem.com.

These services are not covered by your Lumenos plan.