


Isn't it time someone
created a healthier
health plan?

Anthem 

We thought so. So we did.



Lumenos[®] Consumer-Driven Health Plans
for Individuals and Families

A couple is seen from behind, sitting on a stone ledge. They are looking out over a lush green park with a pond in the background. The man is wearing a blue jacket, and the woman is wearing a light blue shirt. The scene is peaceful and scenic, with many trees and bushes.

Anthem's Lumenos plans are for people who want to take more control of their health care and expenses. Does that sound like you?

At Anthem Blue Cross and Blue Shield, we think health plans should do more than pay for care when you're sick. Good health is something to work on all the time. Whether you have a long-term condition, a temporary illness, or even if you're currently in good health, there are things you could be doing to maintain or improve your health. Do you want a health plan that helps you do those things?

We thought so. And we developed a portfolio of health plans whose goal is to give you accounts, information, services and rewards to help maintain and improve your health. These consumer-driven plans – which we call our Lumenos plans – offer the kinds of things that help you reach your health potential and give you more control over your health care dollars, plus a whole lot more.

What makes the Lumenos plans different?

A health account that empowers you and offers flexibility

Lumenos plans give you the ability to better manage and control your health care dollars. They are designed to help you reduce your out-of-pocket health expenses, while improving your health and well-being. Plus, you have three plan choices and a variety of deductible options, so you can tailor the plan to your needs and budget – for even more flexibility.

- OPTION 1: Lumenos Health Savings Account (HSA) Plan
- OPTION 2: Lumenos Health Incentive Account (HIA) Plan
- OPTION 3: Lumenos Health Incentive Account (HIA) Plus Plan

Remember, the higher the deductible, the lower your premium. You'll also need to consider what you can comfortably afford to pay up front for medical care before traditional health coverage begins.

Preventive care covered – before your deductible

When you use our network providers, nationally recommended preventive care services are covered by us, with no additional cost to you. Below are some of the covered preventive care services:

Well Baby and Well Child Preventive Care	Adult Preventive Care
Preventive Physical Exams	Preventive Physical Exams
Immunizations	Immunizations
Screening Tests including the following: <ul style="list-style-type: none">• Eye chart vision screening (full vision exams not included)• Hearing screening• Screening for lead exposure• Pelvic exam and Pap test for females (who are age 18, or have been sexually active)	Screening Tests including the following: <ul style="list-style-type: none">• Eye chart vision screening (full vision exams not included)• Hearing screening• Cholesterol and lipid level screening• Blood glucose test to screen for Type II diabetes• Prostate cancer screenings including digital rectal exam and PSA test• Colorectal cancer screenings including fecal occult blood test, barium enema, flexible sigmoidoscopy and screening colonoscopy• Breast exam and Mammography screening• Pelvic exam and Pap test for females

360° Health® – Personalized services and online tools for health-conscious consumers

360° Health is our approach to surrounding you with the resources, tools, guidance and support to help you make the right health care decisions for you and your family. You'll have access to a wealth of ways to improve and maintain your health – all at no additional charge, including:

- An online MyHealth Assessment designed to help you measure your overall health.
- Our health coaching programs for managing ongoing conditions, and our Healthy Lifestyles programs such as Tobacco-Free and Healthy Weight.
- A 24/7 NurseLine when you need a quick answer to a routine health question or information on a medical issue.
- An online health site with tools and information, including network provider listings, hospital quality ratings, prescription drug costs, wellness articles, and much more.

Built-in value through our discounts

You choose your own doctor and you never need referrals – and when you use our network providers, you can save money because you'll receive our negotiated discounts on services and prescriptions. If you visit an out-of-network provider, you'll still have benefits, but your share of the cost for covered services will increase.

How the Lumenos plans work

Preventive Care

Preventive care to maintain your health.

- 100% coverage for nationally recommended preventive care services with no deduction from your health account and no out-of-pocket costs when you use network providers.
- If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply.
- Preventive care and immunizations for children ages 0 through 6 are covered at 100% of Anthem's allowable charge, with no deduction from your health account and no deductible or out-of-pocket coinsurance whether you use in-network or out-of-network providers.

Health Account

Health account to pay for medical care and prescriptions.

- You can use these funds to pay for covered health expenses.
- You'll earn additional credit for your health account with reward credits* for healthy behaviors. These credits help pay for covered expenses.
- Unused funds roll over from year to year so your account can keep growing to help meet future health care costs.
- The funds you spend from your health account on covered expenses apply to your plan deductible, which must be satisfied before traditional health coverage begins.

Out-of-Pocket "Bridge" to Traditional Health Coverage

Then, use Traditional Health Coverage, if needed.

- Plans include a bridge amount, an annual deductible, coinsurance and an annual out-of-pocket limit. See the Plan Benefits Comparison for specific amounts for each plan.

Bridge

- Once all of the funds in your health account are used to offset your annual deductible, you pay the remaining deductible amount. This payment is called a "bridge" amount because it bridges the health account and traditional health coverage components of the plan.
- Your bridge amount will vary depending on how much of your account you spend to help meet your annual deductible.
- **Health Account + "Bridge" = Annual Deductible**

Plan Deductible

- The plan's annual deductible must be satisfied before traditional health coverage begins.
- Health account funds used for covered medical expenses from both in-network and out-of-network providers apply to your deductible.

Coinsurance

- When traditional health coverage begins, the plan pays the majority of covered expenses, and you pay a percentage of the cost as coinsurance.
- The coinsurance percentage you pay will be less for covered services received from an in-network provider. You will pay a higher coinsurance percentage for services you receive from an out-of-network provider.
- You pay the same coinsurance percentage for most benefits, such as physician office services, urgent care, emergency room and prescription drugs.

Out-of-Pocket Maximum

- The plan pays 100% of in-network covered expenses after you reach the annual out-of-pocket maximum.
- The amount you pay to meet your deductible and your coinsurance payments counts toward the annual out-of-pocket maximum.
- The plan includes a separate out-of-pocket maximum for in-network services and for out-of-network services.

Traditional Health Coverage

* Reward credits available for HIA and HIA Plus plans only.

Three Lumenos plan options

Our portfolio of Lumenos plans offers three choices for individuals and families. You decide which one works best for you:

• **OPTION 1: Lumenos Health Savings Account (HSA) Plan** is funded by your own contributions, which may be tax-deductible. It gives you an account called a Health Savings Account, or HSA, which you can use to pay for medical care and prescriptions; and can lower the amount you have to spend out of your pocket.

Plus, the HSA plan provides an opportunity for tax savings. If you open a Health Savings Account with your Lumenos HSA plan, you can save on taxes in three ways:

- First, contributions you make to your account may be tax-deductible (within certain IRS limits), which can reduce your overall taxes.
- Second, the money in your account can earn tax-free interest and you even have the opportunity to save for the future.
- Third, withdrawals to pay for eligible medical expenses are tax-deferred.

You can also use the money in your HSA to pay for eligible medical expenses that aren't covered by the health plan, like contact lenses, over-the-counter medications, or orthodontic braces (however, these amounts won't apply to your deductible).

• **OPTION 2: Lumenos Health Incentive Account (HIA) Plan** is funded entirely through reward credits you can earn for healthy behaviors. It gives you an account called a Health Incentive Account, or HIA, which you can use to help pay for medical care and prescriptions, and can lower the amount you have to spend out of your pocket.

• **OPTION 3: Lumenos Health Incentive Account (HIA) Plus Plan** is funded with quarterly contributions from Anthem. It gives you an account called a Health Incentive Account, or HIA. You can earn additional reward credits for your account with rewards for healthy behaviors. You can use the health account credits for covered medical care and prescriptions, and can lower the amount you have to spend out of your pocket.

Plan Features	HSA	HIA	HIA Plus
100% coverage for preventive care with no deduction from your health account and no out-of-pocket costs when you use in-network providers	✓	✓	✓
Health account to help pay medical expenses	✓	✓	✓
Health account balance belongs to you if you leave the plan	✓		
Rewards for doing things to improve your health potential		✓	✓
Opportunity for tax savings	✓		
Traditional Health Coverage to protect you against large health expenses	✓	✓	✓
Access to our interactive online health site to help you make better health decisions	✓	✓	✓
Access to personalized services	✓	✓	✓

The key difference among the three is how contributions are made to your health account and how you can use those credits to help pay for health expenses. The HSA Plan offers an opportunity for tax savings while the HIA and HIA Plus Plans provide rewards for activities to improve your health potential.

No matter which plan you choose, our Lumenos plans are designed to make it easier for you to do the right things for your health.

Take a closer look at our Lumenos plan options:

OPTION 1: Lumenos Health Savings Account (HSA) Plan

If you select the Lumenos HSA Plan, you have a separate Health Savings Account (HSA). You can make tax-deductible contributions (with certain IRS limits and requirements) to your account, and withdraw the money tax-free to pay for eligible medical expenses, including prescriptions.

The tax advantages help to lower your out-of-pocket costs, and the money you use from the account applies to your “bridge” responsibility (the amount you must pay out of pocket before traditional health coverage kicks in).

There are other advantages: If you don't spend all the money in a given year, the amount rolls over, so your account keeps growing. **The money in the account is yours to keep – it's never forfeited, even if you leave the health care plan.**

Your HSA can be set up for you with ACS/Mellon Trust of New England® (Mellon) – or you can choose another financial institution. Refer to page 8 to see how easy an HSA with Mellon is for you to use. Consultation with your tax advisor is a wise choice when considering any strategy to maximize tax benefits for your personal circumstances.



How could the Lumenos HSA Plan work for you?

Let's look at one example of how the Lumenos HSA Plan can help individuals and their families. You can view more examples at anthem.com.



STEVE ADAMS

Steve is a healthy 35-year-old who loves skiing and the outdoors. Being healthy is important to him, but he never really thinks about it. Unfortunately, he took a nasty spill on the slopes and had to have knee surgery later in the year. Since his expenses were higher than usual, Steve had some out-of-pocket expenses in his first year. His second year was more typical and he was able to begin to build savings in his HSA for the future.

360° Health services used by Steve:

- Online MyHealth Assessment
- Online physician directory and profiles
- 24/7 NurseLine
- Online fitness program to help Steve stay healthy

STEVE ADAMS' HSA PLAN

Steve contributes \$1,500 to his HSA each year. His plan's deductible is \$2,000. If he chooses to use his HSA to pay for covered services, this will reduce the out-of-pocket amount (the bridge) needed to meet his deductible before the Traditional Health Coverage begins.

Year 1	
HSA: \$1,500 contribution	\$1,500
Total Expenses:	\$4,650
Preventive care services	\$250
Arthroscopic knee surgery	\$4,200
Prescription drugs	\$200
Paid by preventive care benefit - no deduction from HSA	\$250
Expense balance remaining	\$4,400
Amount paid from HSA (Steve's choice)	-\$1,500
Steve pays remainder of bridge amount needed to meet annual deductible (\$2,000 - \$1,500 = \$500)	-\$500
Expense balance remaining	\$2,400
Amount paid by Traditional Health Coverage (100% x \$2,400 = \$2,400)	-\$2,400
Total Amount Plan Pays	-\$2,650
Total Amount Steve Adams Pays (includes Steve's HSA contributions)	-\$2,000
HSA Rollover to Year 2	\$0

Year 2	
HSA Balance: \$1,500 contribution for Year 2	\$1,500
Total Expenses:	\$500
Preventive care services	\$200
Office visits	\$100
Prescription drugs	\$200
Paid by preventive care benefit - no deduction from HSA	\$200
Expense balance remaining	\$300
Amount paid from HSA (Steve's choice)	-\$300
HSA Rollover to Year 3	\$1,200

Since Steve did not spend all of his HSA dollars, he did not need to pay any additional amounts out of pocket this year.

This is an example. Different coinsurance and deductible options may be available, and your actual experience will vary. All expenses assume the use of in-network providers.

Your Lumenos HSA with Mellon Bank

Anthem makes it easy to get your account started. We've partnered with Mellon to make establishing and managing your Health Savings Account simple – we'll even set up the account for you once you're approved for our health plan coverage. Or, if you would rather use another financial institution, that's fine too.

Lumenos HSA with Mellon Key Features

The Lumenos HSA with Mellon provides many useful tools and services:

- a single customer service contact for the health plan and the Health Savings Account
- a single online health site to access your plan benefit information and account details
- competitive interest rates and investment options for the funds in your Health Savings Account

HSA Welcome Kit

If you have selected to use our banking partner on your application form, your Health Savings Account will automatically be established with Mellon once you're approved for the Lumenos HSA plan. A separate application for your account is not required (unless you choose a different financial institution). Soon after you're approved for the plan, you will receive an HSA Welcome Kit with all of the banking documentation and instructions for using your Health Savings Account.

Interest and Investments

You will earn interest on your Health Savings Account funds and will also have the opportunity to invest your funds once your account balance reaches \$3,000. Investment options include a number of mutual funds from the Dreyfus family of mutual funds. Once you are ready to invest, you can request a prospectus for each fund for more details.

Debit Cards and Checkbooks

Use your MasterCard® debit card or your Health Savings Account checkbook – provided by Mellon – to pay your health care provider or pharmacy directly for eligible medical expenses, or to access cash from your account.

Deposits to Your Account

Contribute to your Health Savings Account by sending a check and deposit slip to the address printed on your checkbook. You can also set up an electronic funds transfer between your bank and Mellon for regular account contributions.

Account Activity Statements

Each month, you will receive a statement from Mellon that shows all of your account activity. You will also receive an IRS 1099 form and an IRS 5498 form from Mellon near tax time to assist with tax preparation.

Mellon Health Savings Account Fee and Rate Schedule

The following administrative and banking fees apply to the Health Savings Account with Mellon:

Administrative fees

- One time account set-up fee \$15

Banking fees

- Monthly account fee \$2.95
- Debit card transactions no charge
- Check writing no charge
- ATM transactions \$1
- Card replacement fee \$5
- Check reorder \$10
- Non-sufficient funds \$25
- Stop check service \$25
- Duplicate check \$5

You will receive a Health Savings Account Deposit Agreement and Disclosures and Fee Sheet in your Mellon Welcome Kit after you're approved for the Lumenos HSA Plan. Please refer to those documents for the complete terms and conditions related to your account.

To open a Health Savings Account, the IRS maintains certain eligibility requirements:

- 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

The Lumenos Health Incentive Account (HIA) and Health Incentive Account Plus (HIA Plus) Plans: powerful rewards for your health

With the HIA or HIA Plus Plans, you'll have the opportunity to earn contributions to your health account – while improving your health – by participating in our rewards programs. Reward credits in your health account are used to help you pay part of your annual deductible. And amounts you don't use can roll over to the next year.

How to Earn Reward Credits

The health plan will contribute reward credits into your health account for taking any of the following steps to improve and maintain your health:

- **Completing or updating a MyHealth Assessment**, our online tool designed to help measure your overall health. The health information you provide is secure and strictly confidential. All covered family members may complete the MyHealth Assessment. One adult per family will earn a \$50 credit per year for doing so.
- **Enrolling in and graduating from one of our health coaching programs**, a one-on-one support program intended to help you proactively manage your health. Members who qualify can earn \$100 for enrolling and \$100 for graduating. Members enrolled in more than one health coaching program may only receive one incentive. Please note not all health coaching programs qualify for reward credits.
- **Completing our Tobacco-Free Program**, designed to help you lead a tobacco-free lifestyle. Participation is open to you and your covered family members age 18 or older, and includes counseling support and tools, including nicotine replacement therapy coverage. You and your covered spouse or domestic partner can each earn \$50 for completing the program (one reward per lifetime).
- **Completing our Healthy Weight Program**, personalized phone course with a team of counselors (a registered dietitian and health educator) designed to help you adopt lifestyle changes necessary to lose weight and maintain weight loss. Participation is open to you and your covered family members age 18 and older who have a Body Mass Index (BMI) of 25 or higher. You and your covered spouse or domestic partner can each earn \$50 for completing the program (one reward per lifetime).



OPTION 2: Lumenos Health Incentive Account (HIA) Plan

If you select the Lumenos HIA Plan, your health account is funded entirely through rewards – credit you can earn in your health account for doing the right things for your health. Just like the other Lumenos plans, you can use this credit to pay for covered medical expenses, including prescriptions.

Once all the credit in your health account is spent, you satisfy a limited out-of-pocket responsibility – called a “bridge” – before the traditional health coverage begins. You don’t have to spend it all, though. Unused credit in your account can roll over from year to year, as long as you remain in the plan. (If you leave the plan, however, any credit left in your account is forfeited.)



How could the Lumenos HIA Plan work for you?

Let's look at one example of how the Lumenos HIA Plan can help individuals and their families. You can view more examples at anthem.com.



MARY JONES

Mary is a healthy 25-year-old who works out four days a week.

360° Health services used by Mary:

- Online MyHealth Assessment
- Online MyHealth Record
- Online physician directory and profiles
- Online office visit guidelines
- 24/7 NurseLine
- Tobacco-Free Program to help Mary stop smoking

MARY JONES' HIA PLAN

Mary earns reward credits for her HIA by taking certain steps to improve her health. Her plan's annual deductible is \$1,500 for individual coverage. After she uses all of her HIA dollars, she will pay a limited amount out of pocket (the bridge) to meet her deductible before the Traditional Health Coverage begins.

Year 1		
HIA:	\$50 reward credit for completing online MyHealth Assessment, plus \$50 reward for completing the Tobacco-Free Program	\$100
Total Expenses:		\$450
	Prescription drugs	\$200
	OB/Gyn visit and lab tests	\$150
	Office visits	\$100
Paid by preventive care benefit - no deduction from HIA		\$150
Amount paid from HIA (reward credits)		-\$100
Mary pays additional expense remaining, which is applied toward this year's bridge.		-\$200
HIA Rollover to Year 2		\$0

Year 2		
HIA Balance:	\$0 from Year 1, plus \$50 reward credit for updating the online MyHealth Assessment	\$50
Total Expenses:		\$500
	OB/Gyn visit and lab tests	\$350
	Prescription drugs	\$150
Paid by preventive care benefit - no deduction from HIA		\$350
Amount paid from HIA (reward credits)		-\$50
Mary pays additional expense remaining, which is applied toward this year's bridge.		-\$100
HIA Rollover to Year 3		\$0

This is an example. Different coinsurance and deductible options may be available, and your actual experience will vary. All expenses assume the use of in-network providers.

OPTION 3: Lumenos Health Incentive Account (HIA) Plus Plan

If you choose the Lumenos HIA Plus Plan, we will make quarterly contributions to a health account on your behalf (a fixed amount for individuals and more for families). You use these funds first to pay for covered medical care and prescriptions.

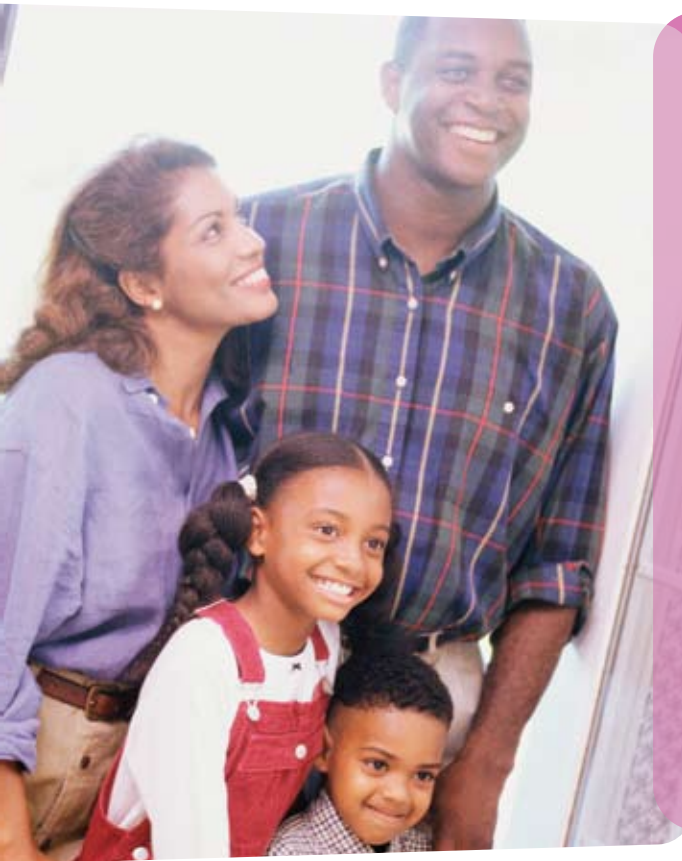
Once all the credit in your health account is spent, you satisfy a limited out-of-pocket responsibility – called a “bridge” – before the traditional health coverage begins. You don’t have to spend it all, though. Unused credit in your account can roll over from year to year, as long as you remain in the plan. (If you leave the plan, however, any credit left in your account is forfeited.)

You also have the opportunity to earn reward credits for your health account for taking certain steps to improve your health.



How could the Lumenos HIA Plus Plan work for you?

Let's look at one example of how the Lumenos HIA Plus Plan can help individuals and their families. You can view more examples at anthem.com.



THE SMITHS

The second year the Smiths were enrolled, Mr. Smith had major surgery for his back. Thanks to their HIA savings from their first year, the Smiths had funds in their HIA account to help cover some of their bridge amount in Year 2.

360° Health services used by all the Smiths:

- Online MyHealth Assessment
- Online MyHealth Record
- Online physician directory and profiles
- Online office visit guidelines
- 24/7 NurseLine
- Online hospital procedure guides - what to expect in the hospital, safety tips and self-care at home – to help with Mr. Smith's back surgery
- MyHealth Coach support for home care after surgery and low back pain

THE SMITHS' HIA PLUS PLAN

The Smiths receive a \$400 annual contribution from the health plan (provided on a quarterly basis) in their HIA account each year. Their plan's annual deductible is \$5,000 for family coverage. If they use all of the credit in their account, they will pay \$4,600 out of pocket (the bridge) to meet their deductible before the Traditional Health Coverage begins.

Year 1		
HIA:	Annual contribution is \$400, plus \$50 reward credit for completing the online MyHealth Assessment	\$450
Total Expenses:		\$650
	Prescription drugs	\$150
	Preventive care services	\$500
Paid by preventive care benefit - no deduction from HIA		\$500
Expense balance remaining		\$150
Amount paid from HIA		-\$150
HIA Plus Rollover to Year 2		\$300

Year 2		
HIA Balance:	\$300 from Year 1, plus \$400 annual contribution for Year 2 and \$50 reward credit for updating the online MyHealth Assessment and \$200 reward credit for enrolling in and graduating from the MyHealth Coach Program	\$950
Total Expenses:		\$15,050
	Preventive care services	\$300
	Hospital and surgery charges	\$14,300
	Prescription drugs	\$450
Paid by preventive care benefit - no deduction from HIA		\$300
Expense balance remaining		\$14,750
Amount paid from Year 2 HIA allocation		-\$400
Year 1 Rollover and reward credits help pay this year's bridge		-\$550
Smiths pay remainder of bridge (\$4,600 - \$550 = \$4,050)		-\$4,050
Expense balance remaining		\$9,750
Amount paid by Traditional Health Coverage (100% x \$9,750 = \$9,750)		-\$9,750
Total Amount HIA and Plan Pay		-\$11,000
Total Amount the Smiths Pay		-\$4,050
HIA Plus Rollover to Year 3		\$0

This is an example. Different coinsurance and deductible options may be available, and your actual experience will vary. All expenses assume the use of in-network providers.



All Lumenos plans include these features

Save on prescription drugs—including mail order

Prescription medications—even through mail order—are covered when the traditional health plan coverage kicks in (less any applicable coinsurance payments). But that doesn't mean you have to wait to save money:

- The cost of the prescription may be paid first from your health account, if you have funds in the account. If you don't have funds in your account, you still benefit from our discount rate.
- Thanks to our buying power, we are able to negotiate significant discounts on all types of prescription medicines. Just show your health plan ID card at pharmacies in our network— that's over 95% of pharmacies nationwide. Your card lets them know your prescription should receive our discount rate.
- To further lower your cost, visit anthem.com (it's easy to register once you're approved in the plan) to learn about generics or other low-cost alternatives that could save you money.
- You may also save on prescriptions by ordering a 90-day supply through mail order. Once you're approved in the plan, you can download a mail order form from anthem.com.

Get plenty of online support and helpful tools

Regardless of the plan option you choose, once you're approved in the plan, simply register at anthem.com for instant access to a wealth of online content designed to help keep you healthy and save money. Some of the tools and information available to you and your eligible dependents include:

- **MyHealth Assessment:** Our online tool designed to help measure your current overall health. The information you provide is secure and strictly confidential.
- **Health Coaching Programs:** One-on-one support programs to help you proactively manage your health. Available if you qualify.
- **Tobacco-Free Program:** A proven program to manage withdrawal symptoms, identify triggers and learn new behaviors and skills to remain tobacco-free. Participation is open to you and eligible dependents age 18 or older, and includes counseling support and tools, including nicotine replacement therapy coverage.
- **Healthy Weight Program:** A personalized phone program designed to help you adopt lifestyle changes necessary to lose weight and maintain weight loss. A team of counselors (a registered dietitian and health educator) with expertise in weight management will advise you on healthy eating, physical activity and exercise, stress management, and more. You and eligible dependents age 18 and older with a Body Mass Index (BMI) of 25 or higher are eligible for this program.
- **SpecialOffers@AnthemSM:** Saves you money on a wide variety of health-related products and services.



Why should a health plan care about your health?

The fact is, good health not only feels better, it costs less, too. Doing what's best for your health is not a short-term fix – it's a long-term solution. And over the long term, living a healthier life can help you save money. Our Lumenos plans are designed to help you do both.

Once you're enrolled in a Lumenos plan, you'll have coverage for preventive care services and a plan that's designed to help you feel better.

If you have an ongoing health condition, you'll have traditional health coverage to protect you against high medical expenses. Plus, our health coaching programs can help you manage certain health conditions for optimal results. And our award-winning online health site can help you maintain and improve your health with tools, information and personalized services.

If you have occasional health expenses, you can save dollars from low-expense years to help pay for care in years with higher expenses. Our online health site can help you prepare for a medical procedure. And if you develop a health condition, our health coaching programs can help you manage it more effectively.

If you have few health expenses, you may be able to enjoy no out-of-pocket costs, and the chance to save health care dollars from year to year for future health care expenses.

If you choose the Lumenos HIA plan or HIA Plus plan, you'll have the opportunity to earn rewards for doing good things for your health.

To all of these benefits, add one more – it's easy to get started. Whether you're looking for individual or family coverage, the application can be filled out and submitted easily and securely online.

In other words, our Lumenos plans are for people who want to take more control of their health care and expenses. *Does that sound like you?*

Visit anthem.com or talk to your Anthem agent today for more information and complete details.



*We're leading a revolution
in health benefits. And the
winner is your health.*

Benefits Available at an Additional Cost

Why pay extra for benefits you won't use? We offer optional coverage that you can add to your plan for an additional cost, to help you find coverage that best fits your life today, and tomorrow.



Maternity

If you're hoping to add to your family in the future, you may want to think about adding maternity coverage now. Conception must occur at least six months after the effective date of this coverage, even if you qualify for credit toward your base policy's 12 month pre-existing waiting period. Pregnant women who are HIPAA "eligible individuals" may not have to wait six months. Your enclosed Anthem application defines HIPAA-eligible individuals. Your Anthem Sales Representative will have more information.

Note: Maternity coverage cannot be added to a policy insuring one male without a female spouse or female domestic partner on the policy, or for female applicants under age 18 unless they are emancipated minors.

The maternity coverage helps pay for:

- childbirth
- prenatal and postnatal care
- use of delivery room
- hospital bed and board for mother
- routine nursery care
- routine newborn circumcision
- cesarean section deliveries and
- diagnostic x-rays and lab charges.

Dental Coverage

Dental coverage is important to your overall health and well-being.

Regular dental check-ups can serve as an early warning for health-related issues. In fact, gum and tooth disease have been linked to a number of major health conditions like heart disease, stroke, respiratory disease and diabetes. Who knew seeing a dentist may help save your life? Protect your smile –and your health – with dental coverage.

You'll save more on the cost of your dental care when you visit a participating network dentist. Going out of the network means you'll be responsible for more of the cost. To find a network dentist in your area visit us at anthem.com.

Preventive Care

COVERED SERVICES	WAITING PERIOD	COINSURANCE		DEDUCTIBLE		MAXIMUM COVERED PER YEAR
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Diagnostic (2 oral exams)	None	0%	50%	None	None	\$1,000 per covered person for preventive, restorative and complex care
X-Rays (1 set of bitewings per year. 1 full mouth series every 3 years for covered persons age 5 and over)						
Preventive (includes cleanings, topical fluoride treatments for children under 16, space maintainers for children under 12)						

Restorative and Complex Care

COVERED SERVICES	WAITING PERIOD	COINSURANCE		DEDUCTIBLE		MAXIMUM COVERED PER YEAR
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Restorative Services (fillings)	6 months	50%	50%	\$50/individual up to \$150/family	\$100/individual up to \$300/family	\$1,000 per covered person for preventive, restorative and complex care
Simple Extractions						
Anesthesia (emergency treatment of dental pain for minor procedures, general anesthesia with oral surgery)						
Oral Surgery (includes root removal, treatment of abscess)	18 months	50%	50%	\$50/individual up to \$150/family	\$100/individual up to \$300/family	\$1,000 per covered person for preventive, restorative and complex care
Prosthodontic Services (includes onlays, crowns, dentures)						
Endodontic Services (root canals)						
Periodontal Services (includes periodontal cleaning, scaling and root planing)						

What if I want to add (or delete) optional coverage later?

Generally, you can add or delete optional coverage on your policy's anniversary date, or when you experience a major life change, including marriage, divorce, legal separation, birth of a child, adoption, death, adding or deleting a dependent, or entering the military.

Important Information You Should Know

We're Committed to Your Privacy

As technology and communication capabilities continue to expand each year, so have concerns about the accessibility of private information. At Anthem, we take your privacy very seriously. The following is a brief outline of the steps we've taken to keep your information safe.

The confidentiality of your medical records is not just protected by law; Anthem goes beyond the law's requirements to ensure your privacy. We require all our employees to sign confidentiality statements keeping your records private. We also contractually require participating health care professionals to keep your medical records confidential. Any medical information we receive on your behalf – to help process your claims, for example – is kept secure and access to this information is limited to approved employees. And for added protection, our offices have employee security systems that tightly control access. When claims data is used in measurement and quality reporting, everyone involved in the analysis signs a confidentiality agreement and findings are reported in ways that do not identify individual patients.

The Virginia Insurance and Privacy Protection Act prohibits the disclosure of personal, privileged or confidential information by an insurer to another party without written authorization from the individual. The law recognizes, however, that in a limited number of situations, an insurer may need to release confidential information without written authorization in order to administer benefits – coordinating care between your primary care physician and your specialist, for example. When your authorization is required, we will not release any information until we receive your (or your legal representative or guardian's) written permission.

An Extra Measure of Coordination and Support

Our plans have several programs and features in place to help coordinate your care as an extra measure of support for you and your family. These programs include:

Admission Review, which is required before all hospital admissions, (except for maternity admissions without complications). Admission Review ensures that you or your family members are receiving the most appropriate care, in the most appropriate setting. Anthem must approve a hospital admission in order for you to receive benefits for that stay.

Network physicians will arrange for Admission Review approval on your behalf. However, if you are treated by a non-network provider, you are responsible for making sure the doctor obtains Admission Review approval. We will respond within 24 hours after notification, unless we need more information to make a decision. For emergency inpatient services, your doctor, you or a family member must contact us within 48 hours of the admission or on the next business day.

Concurrent Review and Discharge Planning, which helps assess the ongoing need for inpatient care and helps plan for the patient's treatment after discharge.

Individual Case Management, a program designed to assist the planning of ongoing care for patients with a catastrophic illness or injury. This service helps our customers coordinate their medical services and/or equipment.

Prescription Drug Benefits

Here are some important facts about our prescription drug benefits:

Prior Authorization

We require prior authorization, or advance approval, for certain prescription drugs, or for quantities that exceed the amount ordinarily prescribed or ordered. To obtain coverage for drugs requiring prior authorization, your physician will need to send a written request along with a copy of applicable medical records. If you choose to purchase these and certain other medications without first getting approval, you will have to pay the full cost. You can find out more about the prior authorization process, including a full list of drugs that require prior authorization, by calling your Anthem Sales Representative.

Generic vs. brand name drugs

Generic Drugs are a cost-saving alternative to brand name drugs. They are regulated by the Federal Drug Administration (FDA), and contain the same active ingredients in the same dosage as the original brand name product. You will receive the highest level of benefits by asking your physician to prescribe a generic drug whenever possible.

Sometimes physicians prescribe medications to be dispensed as written when there are generic alternatives available. To help save money, network pharmacists may discuss with those physicians whether an alternative drug might be appropriate. Physicians always make the final decision on the medications they prescribe.

Coordination of Benefits

If you choose to be covered by two or more types of health insurance, it's important to know our Coordination of Benefits procedures.

Anthem Blue Cross and Blue Shield policies all have a coordination of benefits provision. This provision explains that if you are issued an Anthem Blue Cross and Blue Shield individual policy, and one of the persons covered by your Anthem policy is covered by a group health plan, the group health plan will have primary responsibility for the covered expenses of that family member.

For any dependent children on your Anthem individual policy who are enrolled under another individual health plan, the primary policy is the policy of the parent whose birthday (month and day) falls earlier in the calendar year. Parent birth year is not considered.

Policy Terms

The following are provisions to our policies, which outline specific requirements and procedures about our plans. However, keep in mind that this brochure is not your official policy. The policy you receive when you enroll in a plan will be a legal document that overrides any other descriptions of your coverage. Be sure to read it.

Eligibility

Anthem Blue Cross and Blue Shield Individual Coverage is available only to those who:

- reside in the Anthem Blue Cross and Blue Shield service area; reside in the KeyCare PPO service area;*
- qualify medically and meet certain life-style criteria;
- are under age 65;
- are not entitled to Medicare benefits;
- do not currently have individual protection that provides similar benefits, unless Anthem's individual coverage will replace existing coverage; and
- are not on active duty with any branch of the Armed Services.

Eligible children must also be:

- unmarried; and
- under age 23

To be eligible for coverage as a domestic partner, you:

- must have been living together six or more months and plan to continue living together;
- are financially inter-dependent;
- are at least 18 years old; and
- are not married to anyone else and are not related by blood in a way that would prohibit marriage.

Employees covered by an Anthem Blue Cross Blue Shield group plan are not eligible to purchase individual health insurance policies from Anthem. However, spouses, dependents or domestic partners of the employee are eligible to apply for individual policies.

Renewability

Your coverage is automatically renewed as long as:

- premiums are paid according to the terms of your policy;
- the insured lives, works, or resides in our service area;* and
- there are no fraudulent or material misrepresentations on your application or under the terms of your coverage.

We can refuse to renew your policy if all policies of the same form number are also not renewed. Any such action will be in accordance with applicable state and Federal laws.

Premium

We determine premiums based on such factors as age, sex, type and level of benefits, membership type, health, lifestyle and area of residence. These premiums are set by class. You will never be singled out for a premium change. Your premium may be adjusted periodically. We will give you prior written notice of any premium change we initiate.

Employer payment of premiums

The policies described in this brochure are individual health insurance policies, and, as such, cannot be used as employer-provided health care benefit plans. No employer of any covered person under these policies may contribute to premiums directly or indirectly, including wage adjustments. As it pertains to this section, an employer does not include a trade or business wholly owned by an individual or individual and spouse or domestic partner that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee.

Termination

Coverage ends for all persons insured under the policy if the insured dies. A covered person or guardian of a covered person must contact us to arrange for continued coverage in this instance.

Covered dependent coverage ends under these circumstances:

- for a covered spouse upon divorce from the covered person in whose name the policy was obtained;
- when a covered dependent begins active duty with the Armed Services;
- death of the dependent; or
- at the insured's request.

In addition, coverage ends for covered dependent children under these circumstances:

- at the end of the year in which a covered child turns 23; or
- when the child marries.

If a covered child is incapable of earning a living because of a mental or physical handicap that began before age 23, we will continue to cover the child as long as the policy is in force.

Canceling your policy

If you wish to cancel your Anthem policy, you must call or notify us in writing. Any premium paid beyond your cancellation date will be refunded to you promptly after the cancellation.

Limited Benefit Policy

Our Lumenos plans are "limited benefit policies," meaning that there are times when you may be responsible for more than the 25% maximum coinsurance set by insurance regulations for major medical coverage. This happens only when your copayment or coinsurance is greater than the 25% coinsurance, or when you use an out-of-network provider.

** If you are an "Eligible Individual," as defined on the application, then coverage is available to you if you live, work or reside in our service area or the KeyCare PPO service area.*

What's Not Covered

Remember, all health care plans are different. To choose the plan that best meets your needs, it's important to understand not only what it covers, but what it does not cover.

Exclusions:

Our Individual Lumenos policies do not cover:

Pre-existing conditions

A pre-existing condition is any medical condition you had in the 12 months before your "effective date," or the date you are officially covered by the new policy. During the first 12 months after your effective date, the plans in this brochure do not cover prescription drugs prescribed for a pre-existing condition, services for, or complications resulting from, a pre-existing condition.

The waiting period for pre-existing conditions may be shorter, or waived, if you're transferring your coverage from a qualifying health plan.

Preventive care services

The policy only covers preventive care specified in the policy. It does not cover routine physical examinations, routine laboratory tests or routine x-rays that exceed what is specifically provided for in the policy.

Services not medically necessary

Services or care that are not medically necessary as determined by us, in our sole discretion.

We cover only medically necessary services in order to keep everyone's premiums down and to make sure services are provided in a safe, approved setting. Our licensed medical staff uses careful guidelines based on accepted medical practice to determine whether a service is medically necessary. These guidelines apply to everyone. You can find out whether a particular service or procedure is medically necessary and covered before you receive it, by calling us when you're considering treatment options with your physician. We'll work with you to find the safest and most effective treatment.

Services that are deemed experimental or investigative

Services that we deem, in our sole discretion, to be experimental/investigative, as well as services related to or complications from such procedures, except in certain limited circumstances as listed in the policy.

The Blue Cross and Blue Shield Association has a committee of medical professionals that reviews new medical treatments, examines the current scientific medical literature and recommends coverage for those treatments that are shown to be safe and effective. They do not recommend new treatments that are still experimental or under investigation. Our medical staff follows the committee's recommendations and guidelines to decide whether a new treatment can be covered by the policy.

Organ and tissue transplants, transfusions

Certain organ or tissue transplants that are considered experimental/investigative or not medically necessary.

Maternity and family planning services

Pregnancy related conditions, except complications of pregnancy as specifically provided for in the policy. We only cover complications of a pregnancy that began after your policy started and include conditions that would be considered life-threatening to the mother.

We do not cover family planning services including services and prescription drugs prescribed for or related to artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception. We also do not cover reversals of sterilization which resulted from a previous elective sterilization.

Dental services

Dental care, except as specifically provided for in the policy.

Hearing services

Implantable or removable hearing aids, including exams for prescribing or fitting hearing aids, regardless of the cause of hearing loss, with the exception of cochlear implants.

Vision services

Services for, or related to, procedures performed on the cornea to improve vision, in the absence of trauma or previous therapeutic process. Medical or surgical procedures to correct nearsightedness, far-sightedness, and/or astigmatism.

Foot care

Services for palliative or cosmetic foot care.

Cosmetic services

All medical, surgical, and mental health services for or related to cosmetic surgery and/or cosmetic procedures, including any medical, surgical, and mental health services to correct complications of a person's cosmetic procedure. Body piercing and cosmetic tattooing are considered cosmetic procedures. "Cosmetic surgery," however, does not mean reconstructive surgery incidental to or following surgery caused by trauma, infection, or disease of the involved part. We determine, in our sole discretion, whether surgery is cosmetic or is clearly essential to the physical health of the patient.

Certain types of therapies

Therapy primarily for vocational rehabilitation; certain drugs and therapeutic devices, including over-the-counter drugs and exercise equipment; outpatient services for marital counseling, coma-stimulation activities, educational, vocational, and recreational therapy, manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.

Certain facility and home care

Services for rest cures, residential care or custodial care. Your coverage does not include benefits for care from a residential treatment center or non-skilled, subacute settings, except to the extent such settings qualify as 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.

Transportation services

Travel or transportation, except by professional ambulance services as described in the policy.

Services covered under government programs or employee benefits

Services covered under Federal or state programs (except Medicaid); services for injuries or sickness resulting from activities for wage or profit when 1) your employer makes payment to you because of your condition; 2) your employer is required by law to provide benefits to you; or 3) you could have received benefits for your condition if you had complied with the relevant law.

Services related to the military, war or civil disobedience

Services for injuries or sickness sustained while serving in any branch of the armed forces or resulting from acts of war.

Services for injuries or sickness resulting from participation in a felony, riot or any other act of civil disobedience.

Services provided by family or co-workers

Services performed by your immediate family or by you; services rendered by a provider to a co-worker for which no charge is normally made in the absence of insurance.

Separate charges

Separate charges for services by health care professionals employed by a covered facility which makes those services available.

Prescription drugs

We do not cover:

- prescription drugs prescribed for pre-existing conditions during the first 12 months of coverage;
- over-the-counter drugs;
- charges to administer prescription drugs or insulin, except as stated in the policy;
- prescription refills that exceed the number of refills specified by the provider;
- a prescription that is dispensed more than one year after the order of a physician;
- drugs that are consumed or administered at the place where they are dispensed, except as stated in the policy;
- prescription drugs prescribed for weight loss or as stop-smoking aids;
- prescription drugs prescribed primarily for cosmetic purposes;
- prescription drugs dispensed by anyone other than a pharmacy with the exception of a physician dispensing a one-time dosage of an oral medication either at the physician's office or in a covered outpatient setting in order to treat an acute situation; and
- prescription drugs not approved by the FDA.

Other non-covered services

- Services for which a charge is not normally made.
- Amounts above the allowable charge for a service.
- Services or supplies not prescribed, performed or directed by a provider licensed to do so.
- Services if they are for dates of service before the effective date or after a covered person's coverage ends.
- Telephone consultations, charges for not keeping appointments, or charges for completing forms or copying medical records.
- Services not specifically listed or described in this policy as covered services.
- Services to treat sexual dysfunction, including services for or related to sex transformation, when the dysfunction is not related to organic disease. This includes related medical services and mental health services.
- Complications of non-covered services – these services would include treatment of all medical, mental health and surgical services related to the complication.
- Services or supplies ordered by a physician whose services are not covered under the policy.
- Self-help, training, and self-help administered services.
- Manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.

Out-of-pocket expense limit exclusions

The following items never count toward your out-of-pocket expense limit:

- amounts exceeding the allowable charge and expenses for services not covered under the policy.

Optional Coverage exclusions

Adding optional coverage to your policy changes certain exclusions in your policy related specifically to services for dental care or pregnancy. But other limitations and exclusions continue to apply.

Dental Coverage exclusions

This coverage does not cover:

- services not listed or described in your policy or in the optional coverage as a covered service;
- dental services that are covered under any other dental benefits plan under which a covered person is enrolled;
- dental services with respect to congenital or developmental malformation or primarily for cosmetic purposes except as specified in the optional coverage;
- upgrading of serviceable dentistry;
- services rendered prior to the optional coverage effective date, and services rendered on or after the optional coverage effective date that are directly related to services received before the optional coverage effective date;
- services rendered after the date of termination of the dental coverage;
- dental pit/fissure sealants on other than first and second permanent molars;
- diagnostic photographs;
- dietary instruction or other counseling;
- silicate restorations;
- sedative fillings; root canal therapy on other than permanent teeth; pulp capping (direct or indirect);
- separate charges for pulp vitality tests and bases and liners under restorations;
- therapeutic pulpotomy on other than primary teeth;
- guided tissue regeneration, including flap entry or re-entry and closure;
- gingival curettage;
- separate charges for irrigation or re-evaluation following periodontal therapy;
- periodontal splinting and occlusal adjustments for periodontal purposes;
- controlled release of medications to tooth crevicular tissues for periodontal purposes;
- repositioning appliances or restorations necessary to increase vertical dimensions or restore or correct the occlusion;
- services rendered for purposes other than to eliminate oral disease and/or replace covered missing teeth (mouth rehabilitation);
- gold foil restorations;
- inlays;
- temporary dentures or temporary crowns, or duplicate dentures;
- services to replace teeth that were lost or extracted prior to the rider's effective date;
- services to replace non-functioning teeth;
- fixed bridges when done in conjunction with a removable appliance in the same arch;
- precision attachments for dental appliances;
- tissue conditioning;
- prefabricated resin crowns;
- dental implants and associated services in conjunction with implants;
- consultations (including telephone consultations), charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for providing information in connection with a claim;
- occlusal guards and athletic mouth guards;
- bleaching or whitening of discolored teeth;
- behavior management or hypnosis;
- therapeutic injections;
- orthodontic services;
- separate charges for infection control procedures and procedures to comply with Occupational Safety and Health Administration (OSHA) requirements;
- analgesics (nitrous oxide);
- occlusal analysis;
- tooth desensitizing treatments; and
- When coverage is available for the following services, these services require the performance of diagnostic x-rays six months prior to the earlier of (1) the request for predetermination of such services or (2) the date the services were rendered:
 - more than one (1) crown;
 - fixed prosthetic devices; or
 - surgical extraction of impacted teeth.

If diagnostic x-rays are not performed as specified above, the services listed above are not covered.

Maternity Coverage Exclusions

Maternity coverage covers pregnancies that begin at least six months after the rider becomes effective. Maternity and pregnancy-related benefits are only available to the female insured or the female covered spouse/domestic partner who is at least 18 years of age or an emancipated minor. It does not cover maternity services for dependent children or a male spouse. The six month time period may not apply to you if you meet certain eligibility requirements. Call your Anthem Sales Representative for more details.

Limitations

These policies cover certain services up to a preset limit. Your policy will have detailed information on the benefit limitations that are outlined below. Please call your Anthem Sales Representative if you have questions about limitations.

Benefits with Yearly Limits under these Policies are:

Benefit	Limit Per Calendar Year
· durable medical equipment	\$5,000
· early intervention services (up to age 3)	\$5,000
· manual medical interventions (spinal manipulation)	\$500
· outpatient physical therapy and/or occupational therapy	\$2,000
· outpatient speech therapy	\$500
· home health care services	90 visits
· mental health & substance abuse services	20 outpatient visits; 25 inpatient days. Up to 10 inpatient days may be exchanged for 15 partial days. (1 inpatient day = 1.5 partial days.)
· skilled nursing facility stays	100 days
Prescription Drugs (non-specialty drugs)	
· Prescription Drugs	\$5,000
· Dispensed at Pharmacy	Up to a 34 day supply, or no more than 150 units per prescription, whichever is less.
· Ordered through the Home Delivery Pharmacy Service	Up to a 90 day supply per prescription.

Dental Coverage limitations

Diagnostic

- All covered diagnostic evaluations (whether emergency or non-emergency): 2 each calendar year

Radiographic

- Set of bitewing x-rays (not in same year as full mouth series x-rays): 1 each calendar year
- Full mouth series x-rays for covered persons age 5 and over: 1 every 3 calendar years
- 9 or more bitewing or periapical x-rays taken at one time is considered a full mouth x-ray
- Up to 4 individual periapical films, but not in the same year as a complete mouth x-ray series, (does not apply when rendered in conjunction with emergency treatment.)

Preventive

- Dental cleaning, including periodontal cleanings: 2 each calendar year
- Fluoride application for covered persons under age 16: 2 each calendar year
- Space maintainers for covered persons under age 12: 2 each per lifetime
- Sealants for each unrestored permanent first and second molar for covered persons under age 16: 1 each per lifetime. There must be a lapse of at least 2 years from the time sealants are placed and the time a restoration is performed on the same tooth and surface for benefits to apply.

Restorative

- 1 amalgam or resin restoration (filling) per tooth per surface: 1 per calendar year. White-colored composite resin fillings will only be covered on anterior (front) teeth. If composite resin fillings are done on back teeth, then you are responsible for the difference between our allowable charge and the dentist's charge for amalgam filling restoration.
- 1 pin retention per tooth per calendar year
- 1 stainless steel crown on each primary (baby) tooth: 1 each per lifetime

Endodontics

- Root canal; (anterior, bicuspid or molar) : 1 per tooth every 3 calendar years
- Retreat of previous root canal; (anterior, bicuspid, or molar): 1 per tooth per lifetime
- Apicoectomy/periradicular surgery; (anterior, bicuspid, molar, or additional root) : 1 per root or tooth per lifetime
- Retrograde filling: 1 per root or tooth per lifetime
- Root canals are covered only on permanent teeth:
- Therapeutic pulpotomy are covered only on primary (baby) teeth

Periodontics

- Periodontal cleaning (applies to your 2 cleanings per year): 1 per calendar year
- Periodontal scaling and root planing: 1 per quadrant every 2 calendar years
- Gingivectomy or gingivoplasty: 1 per quadrant every 3 calendar years
- Periodontal osseous (bone) surgery: 1 per quadrant every 3 calendar years
- Full mouth debridement: 1 per lifetime

Prosthodontics

- Services for bridges, crowns, and dentures are only covered for teeth extracted or missing after the rider's effective date, which includes initial placement, unless for an existing bridge more than 5 years old
- Adjustment or repair to partial or complete dentures: 1 per calendar year
- Chairside relining of partial or complete dentures: 1 every 2 calendar year
- 1 onlay, crown or bridge per tooth every 5 calendar years
- 1 partial or complete denture every 5 calendar years
- 1 laboratory rebasing or relining of dentures every 5 calendar years
- 1 crown repair per tooth per lifetime
- 1 crown recementation per tooth per lifetime

Oral Surgery

- Use of anesthesia only in conjunction with surgical procedures
- 1 vestibuloplasty every 3 calendar years

Adjunctive

- 1 palliative (emergency) treatment per calendar year.
- Use of anesthesia only in conjunction with surgical procedures.



This is not your policy and is intended as a brief summary of services. If there is any difference between this page and the policy, the provisions of the policy shall control. To understand the terms of the individual policy you are considering, please read the Policy Terms, including Exclusions and Limitations. This page refers to Policy Form #s 901119-CP.1 et al., Schedule of Benefits Form#s AVA1669, AVA 1671 and AVA1673, Application Form #s AVA1663, AVA1664, AVA1665 or AVA1635 and Optional Coverage forms #s AVA1563 and AVA1393.

The contribution limits set by the U.S. Treasury and the IRS may be increased for inflation annually. These limits include contributions from any source.

Anthem strongly encourages consultation with a tax advisor before establishing a Health Savings Account.

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