

Lumenos Health Incentive Account (HIA)

Outline of Coverage — Major Medical Expense

Offered by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven Connecticut 06473

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you READ YOUR POLICY CAREFULLY.

Major Medical Expense Coverage — Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy.

A Brief Description of Benefits

Covered Service	In-Network Services (*Out-of-Network Services)	
Single Deductible*	\$1,500	\$2,500
Family Deductible**	\$3,000	\$5,000
Member In-Network Coinsurance	20%	20%
(Member Out-of-Network Coinsurance)	(40%)	(40%)
Member Cost-Share Maximum		
Single	\$4,500 (\$9,000)	\$5,000 (\$10,000)
Family	\$9,000 (\$18,000)	\$10,000 (\$20,000)
Lifetime Maximum	Unlimited (\$1,000,000)	

*Single Deductible - Lumenos Health Incentive Account Direct After the allowance is depleted, the Deductible must be satisfied before any Covered Services are paid by the Plan except for Preventive Services which are not subject to the Deductible.

**Family Deductible — Lumenos Health Incentive Account Direct After the allowance is depleted, the family Deductible must be satisfied before any Covered Services are paid by the plan except for Preventive Services which are not subject to the Deductible. The family Deductible may be satisfied by one Member or all Members collectively.

Note: Single Out of Pocket Limit — Once the Member Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member for the remainder of the benefit period except for Out-of-Network Human Organ and Tissue Transplant services. Family Out of Pocket Limit — Once the family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the benefit period except for Out-of-Network Human Organ and Tissue Transplant services. In Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate toward each other.

Hospital Services

All Inpatient Admissions	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Specialty Hospital <i>100 days per Member per Calendar Year (for other than Mental Health and Substance Abuse services only)</i>	Same as Hospital Inpatient Cost-Share (Deductible and Out-of-Network Coinsurance)
Outpatient Surgery <i>In a licensed ambulatory surgical center (including colonoscopy)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Skilled Nursing Facility <i>Up to 100 days per Calendar Year</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)

Mental Health and Substance Abuse Services

A Brief Description of Benefits (continued)

Covered Service	In-Network Services (*Out-of-Network Services)
Outpatient Treatment for Mental Health Care and Substance Abuse Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Inpatient Hospital Services <i>In a Hospital or Residential Treatment Center for Mental Health Care</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Inpatient Rehabilitation Treatment for Substance Abuse Care <i>In a Hospital or Substance Abuse Treatment Facility</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Miscellaneous Hospital Services	
Emergency Room Treatment	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Urgent Care Services	Deductible and In-Network Coinsurance (Paid as an In-Network Emergency Room)
Surgical Services	
Outpatient surgery <i>In a licensed ambulatory surgical center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Medical Office Visit	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
In-Hospital Medical Services	
Services of a Physician or Surgeon <i>(other than a medical office visit)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Out-of-Hospital Care	
Well Child Care	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Adult Physical Examinations	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Other Preventive Screenings <i>Including but not limited to:</i>	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
<ul style="list-style-type: none"> · Routine gynecological care: pap smear and pelvic exam · Mammography screening · Flexible sigmoidoscopy · Total Cholesterol screening · Diabetic screening 	<ul style="list-style-type: none"> · Prostate screening · Colorectal Cancer screening · Colonoscopy · Lipid screening and panels
Other Benefits	
Immunizations and Vaccinations <i>(other than those needed for travel)</i>	No Cost Share (Deductible and Out-of-Network Coinsurance)
Immunizations and Vaccinations for Travel	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Prescription Drugs <i>The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30-day supply</i> <i>Diabetic drugs and supplies</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Diagnostic Services <i>(Diagnostic, Laboratory, X-ray, MRI, MRA, CAT, CTA, PET and SPECT)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

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A Brief Description of Benefits (continued)

Covered Service	In-Network Services (*Out-of-Network Services)
Infertility Services <i>Office Visit</i> <i>Outpatient Hospital</i> <i>Inpatient Hospital</i> <i>Infertility drugs (with infertility diagnosis). Maximum drug supply for which benefits will be provided when dispensed under any one prescription is a 30 day supply.</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Outpatient Rehabilitation Services <i>Rehabilitative and restorative physical, occupational and speech therapy (\$3,000 combined max. per member per calendar year)</i> <i>(Chiropractic therapy (max. 12 visits per calendar year))</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Other Therapy Services <i>Outpatient cardiac rehabilitation therapy; Radiation therapy; Chemotherapy for cancer treatment; Electroshock therapy; Kidney Dialysis in a hospital or free standing dialysis center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Allergy Office Visit/Testing <i>Allergy Injections</i> <i>Unlimited Immunotherapy or other therapy treatments</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ambulance Services <i>Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule</i>	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Human Organ and Tissue Transplant Services <i>Unlimited Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Home Health Care <i>Nursing and therapeutic services limited to 100 visits</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Infusion Therapy <i>Unlimited Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Durable Medical Equipment <i>Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of \$1,000 within a 2 year period.</i>	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Diabetic Equipment <i>Drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier</i>	Deductible and In-Network Coinsurance (if applicable) (Deductible and Out-of-Network Coinsurance)
Ostomy Related Services	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Hospice Care (inpatient)	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Wig <i>Up to \$500 max. per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Specialized Formula	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Nutritional Counseling <i>With a maximum of 3 visits per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

*Out-of-Network Services are noted in parentheses.

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.

Lumenos Health Incentive Account Plus (HIA)

Outline of Coverage — Major Medical Expense

Offered by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven Connecticut 06473

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A Brief Description of Benefits

Covered Service	In-Network Services (*Out-of-Network Services)
Single Deductible*	\$2,500
Family Deductible**	\$5,000
Member In-Network Coinsurance (Member Out-of-Network Coinsurance)	20% (40%)
Member Cost-Share Maximum	
Single	\$5,000 (\$10,000)
Family	\$10,000 (\$20,000)
Lifetime Maximum	Unlimited (\$1,000,000)

*Single Deductible Lumenos Health Incentive Account Plus Direct After the allowance is depleted, the Deductible must be satisfied before any Covered Services are paid by the Plan except for Preventive Services which are not subject to the Deductible.

**Family Deductible — Lumenos Health Incentive Account Plus Direct After the allowance is depleted, the family Deductible must be satisfied before any Covered Services are paid by the plan except for Preventive Services which are not subject to the Deductible. The family Deductible may be satisfied by one Member or all Members collectively.

Note: Single Out of Pocket Limit — Once the Member Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member for the remainder of the benefit period except for Out of Network Human Organ and Tissue Transplant services.
Family Out of Pocket Limit — Once the family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the benefit period except for Out-of-Network Human Organ and Tissue Transplant services.
In Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate toward each other.

Hospital Services

All Inpatient Admissions	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Specialty Hospital <i>100 days per Member per Calendar Year (for other than Mental Health and Substance Abuse services only)</i>	Same as Hospital Inpatient Cost-Share (Deductible and Out-of-Network Coinsurance)
Outpatient Surgery <i>In a licensed ambulatory surgical center (including colonoscopy)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Skilled Nursing Facility <i>Up to 100 days per Calendar Year</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)

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A Brief Description of Benefits (continued)

Covered Service	In-Network Services (*Out-of-Network Services)
Mental Health and Substance Abuse Services	
Outpatient Treatment for Mental Health Care and Substance Abuse Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Inpatient Hospital Services <i>In a Hospital or Residential Treatment Center for Mental Health Care</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Inpatient Rehabilitation Treatment for Substance Abuse Care <i>In a Hospital or Substance Abuse Treatment Facility</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Miscellaneous Hospital Services	
Emergency Room Treatment	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Urgent Care Services	Deductible and In-Network Coinsurance (Paid as an In-Network Emergency Room)
Surgical Services	
Outpatient surgery <i>In a licensed ambulatory surgical center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Medical Office Visit	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
In-Hospital Medical Services	
Services of a Physician or Surgeon <i>(other than a medical office visit)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Out-of-Hospital Care	
Well Child Care	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Adult Physical Examinations	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Other Preventive Screenings <i>Including but not limited to:</i>	No Cost Share In-Network (Deductible and Out-of-Network Coinsurance)
<ul style="list-style-type: none"> · Routine gynecological care: pap smear and pelvic exam · Mammography screening · Flexible sigmoidoscopy · Total Cholesterol screening · Diabetic screening 	<ul style="list-style-type: none"> · Prostate screening · Colorectal Cancer screening · Colonoscopy · Lipid screening and panels
Other Benefits	
Immunizations and Vaccinations <i>(other than those needed for travel)</i>	No Cost Share (Deductible and Out-of-Network Coinsurance)
Immunizations and Vaccinations for Travel	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Prescription Drugs <i>The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30-day supply</i> <i>Diabetic drugs and supplies</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Diagnostic Services <i>(Diagnostic, Laboratory, X-ray, MRI, MRA, CAT, CTA, PET and SPECT)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

A Brief Description of Benefits (continued)

Covered Service	In-Network Services (*Out-of-Network Services)
Infertility Services <i>Office Visit</i> <i>Outpatient Hospital</i> <i>Inpatient Hospital</i> <i>Infertility drugs (with infertility diagnosis). Maximum drug supply for which benefits will be provided when dispensed under any one prescription is a 30 day supply.</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Outpatient Rehabilitation Services <i>Rehabilitative and restorative physical, occupational and speech therapy (\$3,000 combined max. per member per calendar year) Chiropractic therapy (max. 12 visits per calendar year)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Other Therapy Services <i>Outpatient cardiac rehabilitation therapy; Radiation therapy; Chemotherapy for cancer treatment; Electroshock therapy; Kidney Dialysis in a hospital or free standing dialysis center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Allergy Office Visit/Testing <i>Allergy Injections</i> <i>Unlimited Immunotherapy or other therapy treatments</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ambulance Services <i>Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule</i>	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Human Organ and Tissue Transplant Services <i>\$1,000,000 Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Home Health Care <i>Nursing and therapeutic services limited to 100 visits</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Infusion Therapy <i>Unlimited Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Durable Medical Equipment <i>Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of \$1,000 within a 2 year period.</i>	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Diabetic Equipment <i>Drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier</i>	Deductible and In-Network Coinsurance (if applicable) (Deductible and Out-of-Network Coinsurance)
Ostomy Related Services	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Hospice Care (inpatient)	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Wig <i>Up to \$500 max. per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Specialized Formula	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Nutritional Counseling <i>with a maximum of 3 visits per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

*Out-of-Network Services are noted in parentheses.

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.