The following Notices are required by the laws surrounding health care plans. Please review these notices. If you have any questions, please contact Cary Furniss at 513-842-5018.

**USERRA**

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

**Your Rights After a Mastectomy**

*Women’s Health and Cancer Rights Act of 1998*

Under Federal law, Group Health Plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

These services must be provided in a manner determined in consultation between the attending Physician and the patient. Call your Anthem BlueCross BlueShield Customer Service Representative at 1-800-552-9159 for more information.

**Newborns and Mothers Health Protection Act (NMHPA)**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law
generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**HIPAA Special Enrollment Notice**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment 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.

To request special enrollment or obtain more information, contact your District’s Treasurer’s Office.

**Additional Required Notices Are Attached:**

- Summary of Benefits and Coverage (Exhibit A-1) – *PPACA Requirement*
  - Uniform Glossary (Exhibit A-2)
- CMS Medicare Part D Notice (Creditable Coverage) - (Exhibit B) – *must be distributed annually by October 15th*
- CHIP Notice (Exhibit C)
- Notice of Privacy Practices (Exhibit D)
### Greater Cincinnati Insurance Consortium

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage Period:** 07/01/2014 – 06/30/2015  
**Coverage for:** Individual/Family  
**Plan Type:** PPO

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com](http://www.anthem.com) or by calling 1-800-552-9159.

### Important Questions | Answers | Why this Matters:
--- | --- | ---

**What is the overall deductible?**<br>For in-network providers, $600 individual / $1,200 family<br>For out-of-network providers, $1,200 individual/ $2,400 family<br>Doesn’t apply to in-network preventive care. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. | 

**Are there other deductibles for specific services?**<br>No. | You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. | 

**Is there an out-of-pocket limit on my expenses?**<br>Yes. For in-network providers, $3,600 individual / $7,200 family<br>For out-of-network providers, $6,200 individual/ $12,400 family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. | 

**What is not included in the out-of-pocket limit?**<br>Premiums, prescription drug claims, balance-billed charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. | 

**Is there an overall annual limit on what the plan pays?**<br>No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. | 

**Does this plan use a network of providers?**<br>Yes. For a list of [network providers](http://www.anthem.com), see www.anthem.com or call 1-800-552-9159 | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**. | 

**Do I need a referral to see a specialist?**<br>No. | You can see the **specialist** you choose without permission from this plan. | 

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**Questions:** Call 1-800-552-9159 or visit us at [www.anthem.com](http://www.anthem.com)  
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Greater Cincinnati Insurance Consortium

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2014 – 06/30/2015

Coverage for: Individual/Family | Plan Type: PPO

<table>
<thead>
<tr>
<th>Are there services this plan doesn’t cover?</th>
<th>Yes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.</td>
<td></td>
</tr>
</tbody>
</table>

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copayment</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copayment</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$25/$50 (PCP/SCP) copayment</td>
<td>40% coinsurance</td>
<td>Chiropractic Therapy is limited to 12 visits per calendar year. Acupuncture is not covered.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-552-9159 or visit us at www.anthem.com
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com or call 1-800-552-9159 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 – typically generic drugs</td>
<td>$10 copayment for Retail and Home Delivery</td>
<td>50% coinsurance, minimum $40 for Retail</td>
<td>In-network retail pharmacy limits to a 31-day supply. Home delivery limits to a 90-day supply. Home delivery is not covered for out-of-network Providers.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 – typically preferred brand drugs</td>
<td>$40 copayment for Retail and $100 copayment for Home Delivery</td>
<td>50% coinsurance, minimum $40 for Retail</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 – typically non-preferred brand drugs</td>
<td>$60 copayment for Retail and $180 copayment for Home Delivery</td>
<td>50% coinsurance, minimum $40 for Retail</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 – typically specialty drugs</td>
<td>20% coinsurance with $250 maximum for Retail and Home Delivery</td>
<td>Not Covered</td>
<td>Specialty drugs are limited to a 31-day supply regardless of whether they are retail or home delivery. Out of pocket limit of $2500.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$200 copayment</td>
<td>$200 copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 copayment</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$25 copayment</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost If You Use an In-network Provider</td>
<td>Your Cost If You Use an Out-of-network Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Home health care is limited to 100 visits combined network and non-network per calendar year.</td>
</tr>
<tr>
<td>Home health care</td>
<td>$25/$50 (PCP/SCP) copayment</td>
<td>$25/$50 (PCP/SCP) copayment</td>
<td>40% coinsurance</td>
<td>Cardiac Rehabilitation is limited to 36 visits per calendar year. Physical and Occupational Therapy are limited to 30 visits each per calendar year. Pulmonary Rehabilitation and Speech Therapy are limited to 20 visits each per calendar year. All visit limits are combined network and non-network.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$25/$50 (PCP/SCP) copayment</td>
<td>$25/$50 (PCP/SCP) copayment</td>
<td>40% coinsurance</td>
<td>All rehabilitation and habilitation visits count toward your rehabilitation visit limit.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Skilled nursing facility is limited to 90 visits combined network and non-network per calendar year.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Skilled nursing facility is limited to 90 visits combined network and non-network per calendar year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Preventive exam.</td>
</tr>
<tr>
<td>Hospice service</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Preventive exam.</td>
</tr>
<tr>
<td>Eye exam</td>
<td>No Charge</td>
<td>No Charge</td>
<td>40% coinsurance</td>
<td>Preventive exam.</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Preventive exam.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Preventive exam.</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

**Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Routine eye care
- Coverage provided outside the United States. See [www.BCBS.com/bluecardworldwide](http://www.BCBS.com/bluecardworldwide)
- Non-emergency care when traveling outside the U.S.

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-552-9159. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Questions:** Call 1-800-552-9159 or visit us at [www.anthem.com](http://www.anthem.com)

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Anthem Grievance and Appeals
PO Box 105568
Atlanta, GA 30348

Department of Labor’s Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform

Ohio Department of Insurance Consumer Services Division
50 West Town Street, Third Floor, Suite 300
Columbus, OH 43215
1-800-686-1526
http://insurance.ohio.gov

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非会员并且需要中文协助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangayring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangayring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a’bah ni’liigoo ei dooda’i, shik’a adoolwoł ñíñizinigi t’áá diné k’éjjígo, t’áá shoodí ba na’alnhí ya sidáhí bich’í naabííñii. Eí doo biigha daago ni ba’nija’go ho’aalágii bich’í hodúñí. Hai’dàa iiní’taago ciya, t’áá shoodí diné ya atáh halne’ííí ni béésh bee hane’e wólta’ bí’ki si’níiligí bí’kéehgo bich’í hodúñí.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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### Greater Cincinnati Insurance Consortium

**Coverage Period:** 07/01/2014 – 06/30/2015  
**Coverage for:** Individual/ Family | **Plan Type:** PPO

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

---

### Having a baby  
(normal delivery)

- **Amount owed to providers:** $7,540  
- **Plan pays:** $5,740  
- **Patient pays:** $1,800

#### Sample care costs:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,540</td>
</tr>
</tbody>
</table>

#### Patient pays (Individual Plan):

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copays</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,010</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,800</td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes  
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400  
- **Plan pays:** $3,880  
- **Patient pays:** $1,520

#### Sample care costs:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,400</td>
</tr>
</tbody>
</table>

#### Patient pays (Individual Plan):

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copays</td>
<td>$610</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$230</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,520</td>
</tr>
</tbody>
</table>

---

**Questions:** Call 1-800-552-9159 or visit us at www.anthem.com  
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com or call 1-800-552-9159 to request a copy.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✔ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✔ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-552-9159 or visit us at www.anthem.com
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com or call 1-800-552-9159 to request a copy.
Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

- **Bold blue** text indicates a term defined in this Glossary.

- See page 4 for an example showing how **deductibles, co-insurance** and **out-of-pocket limits** work together in a real life situation.

### Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

### Appeal

A request for your health insurer or plan to review a decision or a grievance again.

### Balance Billing

When a provider bills you for the difference between the provider’s charge and the **allowed amount.** For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may **not** balance bill you for covered services.

### Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance plus any **deductibles** you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

### Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren’t complications of pregnancy.

### Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

### Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

### Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

### Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

### Emergency Medical Transportation

Ambulance services for an **emergency medical condition.**

### Emergency Room Care

**Emergency services** you get in an emergency room.

### Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.
Excluded Services
Health care services that your health insurance or plan doesn’t pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn’t require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
How You and Your Insurer Share Costs - Example

Jane’s Plan Deductible: $1,500  
Co-insurance: 20%  
Out-of-Pocket Limit: $5,000

January 1st  
Beginning of Coverage Period

Jane pays 100%  
Her plan pays 0%

Jane hasn’t reached her $1,500 deductible yet  
Her plan doesn’t pay any of the costs.  
Office visit costs: $125  
Jane pays: $125  
Her plan pays: $0

January 1st  
Beginning of Coverage Period

more costs

Jane pays 20%  
Her plan pays 80%

Jane reaches her $1,500 deductible, co-insurance begins  
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.  
Office visit costs: $75  
Jane pays: 20% of $75 = $15  
Her plan pays: 80% of $75 = $60

more costs

January 1st  
Beginning of Coverage Period

Jane pays 0%  
Her plan pays 100%

Jane reaches her $5,000 out-of-pocket limit  
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.  
Office visit costs: $200  
Jane pays: $0  
Her plan pays: $200

December 31st  
End of Coverage Period
Important Notice from Greater Cincinnati Insurance Consortium About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about
your current prescription drug coverage with Greater Cincinnati Insurance Consortium and the
prescription drug coverage available since January 1, 2006 for people with Medicare. It also tells you
where to find more information to help you make decisions about your prescription drug coverage.

1. Since January 1, 2006, Medicare prescription drug coverage has been available to everyone
   with Medicare.

2. Anthem has determined that the prescription drug coverage offered by Greater
   Cincinnati Insurance Consortium is, on average for all plan participants, expected to pay out
   as much as the standard Medicare prescription drug coverage will pay.

3. Read this notice carefully – it explains the options you have under Medicare prescription
   drug coverage, and can help you decide whether or not you want to enroll.

You may have heard about Medicare’s prescription drug coverage, and wondered how it would affect you. Anthem has determined that your prescription drug coverage with Greater Cincinnati Insurance Consortium is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Since January 1, 2006, prescription drug coverage has been available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for higher monthly premiums.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan from October 15, 2014 through December 7, 2014. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each subsequent year, you will again have the opportunity to enroll in a Medicare prescription drug plan between October 15th and December 7th.

If you do decide to enroll in a Medicare prescription drug plan and drop your Greater Cincinnati Insurance Consortium prescription drug coverage, be aware that you may not be able to get this coverage back.

If you drop your coverage with Greater Cincinnati Insurance Consortium and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
You should also know that if you drop or lose your coverage with Greater Cincinnati Insurance Consortium and don’t enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after December 7, 2014 you go 63 days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium will go up at least 1% per month for every month after December 7, 2014 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You’ll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next October to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after December 7, 2014, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: August 20, 2014
Name of Entity/Sender: EPC Benefits Office
Address: 303 Corporate Center Drive, Suite 208, Vandalia, Ohio 45377
Phone Number: (937) 890-3725
**Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Medicaid</th>
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<tbody>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Medicaid Phone (In state): 1-800-866-3513</td>
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<td>Medicaid Phone (Out of state): 1-800-221-3943</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<tr>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
<td>Website: <a href="https://www.flm%D0%B5%D0%B4icaidtplrecovery.com">https://www.flmедicaidtplrecovery.com</a></td>
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<tr>
<td>Phone (Outside of Anchorage): 1-888-318-8890</td>
<td>Phone: 1-877-357-3268</td>
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<tr>
<td>Phone (Anchorage): 907-269-6529</td>
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<tr>
<th>ARIZONA – CHIP</th>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a></td>
<td>Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)</td>
</tr>
<tr>
<td>Phone (Outside of Maricopa County): 1-877-764-5437</td>
<td>Phone: 1-800-869-1150</td>
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<tr>
<td>Phone (Maricopa County): 602-417-5437</td>
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<tr>
<th>IDAHO – Medicaid</th>
<th>MONTANA – Medicaid</th>
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<tr>
<td>Medicaid Website: <a href="http://healthandwelfare.idaho.gov/Medical/medicaid/premium">http://healthandwelfare.idaho.gov/Medical/medicaid/premium</a></td>
<td>Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a></td>
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<tr>
<td>State</td>
<td>Medicaid Website</td>
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<td>INDIANA – Medicaid</td>
<td>Website: <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a></td>
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<tr>
<td>IOWA – Medicaid</td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a></td>
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<tr>
<td>KENTUCKY – Medicaid</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
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<tr>
<td>LOUISIANA – Medicaid</td>
<td>Website: <a href="http://www.lahealth.hhs.louisiana.gov">http://www.lahealth.hhs.louisiana.gov</a></td>
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<td>MAINE – Medicaid</td>
<td>Website:</td>
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<tr>
<td>MASSACHUSETTS – Medicaid and CHIP</td>
<td>Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
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<tr>
<td>MINNESOTA – Medicaid</td>
<td>Website: <a href="http://www.dhs.state.mn.us/Click">http://www.dhs.state.mn.us/Click</a> on Health Care, then Medical Assistance</td>
</tr>
<tr>
<td>MISSOURI – Medicaid</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
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<tr>
<td>OKLAHOMA – Medicaid and CHIP</td>
<td>UTAH – Medicaid and CHIP</td>
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<tr>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a></td>
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<tr>
<td>Phone: 1-888-365-3742</td>
<td>Phone: 1-866-435-7414</td>
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<tr>
<th>OREGON – Medicaid</th>
<th>VERMONT – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a></td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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<tr>
<td>Phone: 1-800-699-9075</td>
<td>Phone: 1-800-250-8427</td>
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<tr>
<th>PENNSYLVANIA – Medicaid</th>
<th>VIRGINIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a></td>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
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<tr>
<td>Phone: 1-800-692-7462</td>
<td>Medicaid Phone: 1-800-432-5924</td>
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<tr>
<th>RHODE ISLAND – Medicaid</th>
<th>WASHINGTON – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a></td>
<td>Website: <a href="http://www.hca.wa.gov/medicaid/premptymnt/pages/index.aspx">http://www.hca.wa.gov/medicaid/premptymnt/pages/index.aspx</a></td>
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<tr>
<td>Phone: 401-462-5300</td>
<td>Phone: 1-800-562-3022 ext. 15473</td>
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<tr>
<th>SOUTH CAROLINA – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a></td>
</tr>
<tr>
<td>Phone: 1-888-549-0820</td>
<td>Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<tr>
<th>SOUTH DAKOTA - Medicaid</th>
<th>WISCONSIN – Medicaid</th>
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<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a></td>
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<tr>
<td>Phone: 1-888-828-0059</td>
<td>Phone: 1-800-362-3002</td>
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<tr>
<th>TEXAS – Medicaid</th>
<th>WYOMING – Medicaid</th>
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<td>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
<td>Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a></td>
</tr>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Phone: 307-777-7531</td>
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To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

<table>
<thead>
<tr>
<th>U.S. Department of Labor</th>
<th>U.S. Department of Health and Human Services</th>
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<tr>
<td>Employee Benefits Security Administration</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>1-866-444-EBSA (3272)</td>
<td>1-877-267-2323, Menu Option 4, Ext. 61565</td>
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</tbody>
</table>

OMB Control Number 1210-0137 (expires 10/31/2016)
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Greater Cincinnati Insurance Consortium

Mr. David Distel, Privacy Official
c/o Hamilton County Educational Service Center, 11083 Hamilton Avenue, Cincinnati, OH 45231
Phone: 513.674.4236 / Email: Dave.distel@hcesc.org
www.readingschools.org

Effective Date of Notice: September 23, 2013

Your Rights

You have the right to:

• Get a copy of your health and claims records
• Correct your health and claims records
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

• Answer coverage questions from your family and friends
• Provide disaster relief
• Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

• Help manage the health care treatment you receive
• Run our organization
• Pay for your health services
• Administer your health plan
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests and work with a medical examiner or funeral director
Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on page 1.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in payment for your care
• Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

• Marketing purposes
• Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you.
## Greater Cincinnati Insurance Consortium
### Blue Access® (PPO)
**Effective July 1, 2014**

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (Single/Family)</strong></td>
<td>$600/$1,200</td>
<td>$1,200/$2,400</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit (Single/Family)</strong></td>
<td>$3,600/$7,200</td>
<td>$6,200/$12,400</td>
</tr>
<tr>
<td><strong>Physician Home and Office Services (PCP/SCP)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP)/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Care Physician (SCP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including Office Surgeries and allergy serum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- allergy injections (PCP and SCP)</td>
<td>$5</td>
<td>40%</td>
</tr>
<tr>
<td>- allergy testing</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>- MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and pharmaceutical products</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings</td>
<td>No copayment/coinsurance</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Emergency and Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>- facility/other covered services (copayment waived if admitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Center Services</strong></td>
<td>$75</td>
<td>40%</td>
</tr>
<tr>
<td>- MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-maternity related Ultrasounds and pharmaceutical products</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>- Allergy injections</td>
<td>$5</td>
<td>40%</td>
</tr>
<tr>
<td>- Allergy testing</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Inpatient and Outpatient Professional Services</strong></td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Include but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Blue 7.6
# Your Summary of Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Facility Services</strong> (Network/Non-Network combined) Unlimited days except for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>- 90 days for skilled nursing facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outpatient Surgery Hospital/Alternative Care Facility</strong></th>
<th>20%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Surgery and administration of general anesthesia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other Outpatient Services</strong> including but not limited to:</th>
<th>20%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Home Care Services 100 visits (excludes IV Therapy) (Network/Non-Network combined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Durable Medical Equipment, Orthotics and Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physical Medicine Therapy Day Rehabilitation programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospice Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ambulance Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outpatient Therapy Services</strong> (Combined Network &amp; Non-Network limits)</th>
<th>$25/$50</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Physician Home and Office Visits (PCP/SCP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other Outpatient Services @ Hospital/Alternative Care Facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Limits apply to:                                                        |         |             |
| - Cardiac Rehabilitation 36 visits                                      |         |             |
| - Pulmonary Rehabilitation 20 visits                                   |         |             |
| - Physical Therapy: 30 visits                                          |         |             |
| - Occupational Therapy: 30 visits                                      |         |             |
| - Manipulation Therapy: 12 visits                                      |         |             |
| - Speech therapy: 20 visits                                            |         |             |

| **Accidental Dental**: $3,000 per accident (Network and Non-network combined) | Copayments/Coinsurance based on setting where covered services are received | 40%         |

<table>
<thead>
<tr>
<th><strong>Behavioral Health:</strong> Mental Illness and Substance Abuse¹</th>
<th>Benefits provided in accordance with Federal Mental Health Parity</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Home and Office Visits (PCP/SCP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Outpatient Services @ Hospital/Alternative Care Facility, Outpatient Professional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Human Organ and Tissue Transplants²</strong></th>
<th>NCS</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquisition and transplant procedures, harvest and storage.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Your Summary of Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Tier structure equals 1/2/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(and 4, if applicable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Network Retail Pharmacies:</td>
<td>$10/$40/$60/20% with $250 maximum</td>
<td>50%, min $40³</td>
</tr>
<tr>
<td>(31-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Home Delivery Service:</td>
<td>$10/$100/$180/20% with $250 maximum</td>
<td>Not covered</td>
</tr>
<tr>
<td>(90-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes diabetic test strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Rx - Wrap</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Medications</strong> are limited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>up to a 31 day supply regardless of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>whether they are retail or mail service.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes:
- All medical deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Prescription Drug cost share options and Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment & (%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.
- No cost share (NCS) means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year.
- Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.

1. We encourage you to review the Schedule of Benefits for limitations.
2. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
3. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
Your Summary of Benefits

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: none

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

This summary of benefits is intended to be a brief outline of coverage. 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.
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact .

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

---

1 An employer-sponsored health plan meets the “minimum value standard” if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Employer address</td>
<td>6. Employer phone number</td>
</tr>
<tr>
<td>7. City</td>
<td>8. State</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) | 12. Email address

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [ ] All employees.
  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [ ] We do offer coverage. Eligible dependents are:

  - [ ] We do not offer coverage.

[ ] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
   - Yes (Continue)
   - No (STOP and return this form to employee)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? __________ (mm/dd/yyyy) (Continue)

14. Does the employer offer a health plan that meets the minimum value standard*?
   - Yes (Go to question 15)
   - No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for this plan? $
   b. How often?  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
   - Employer won't offer health coverage
   - Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
   a. How much will the employee have to pay in premiums for that plan? $
   b. How often?  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  Yearly

Date of change (mm/dd/yyyy):

---

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)