

Your Benefits



Lumenos Health Savings Accounts Option 14 Summary of Benefits

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage. Network and Non-Network deductibles are combined.	Single: \$2,000 Family: \$4,000	Single: \$2,000 Family: \$4,000
Out-of-Pocket Limit	Single: \$5,000 Family: \$10,000	Single: \$10,000 Family: \$20,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) · Including Office Surgeries, allergy serum, allergy injections and allergy testing	20%/20%	40%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams, Routine Mammograms, Diabetic Education, and Certain Medical Nutritional Therapy (Network only). · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility	No Cost Share	40% 40%
Emergency and Urgent Care · Emergency Room Services @Hospital (facility/other covered services) <i>(copayment waived if admitted)</i> · Urgent Care Center Services	20% 20%	20% 20%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	20%	40%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 100 days Network/Non-Network combined for skilled nursing facility	20%	40%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) · Durable Medical Equipment and Orthotics (Network/Non-network combined) \$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) · Prosthetic Devices \$4,000 benefit maximum · Physical Medicine Therapy Day Rehabilitation programs · Hospice Care · Ambulance Services	20% 0% 20%	40% 0% 20%

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Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical therapy: 20 visits Occupational therapy: 20 visits Manipulation therapy: 12 visits Speech therapy: 20 visits 	20%/20% 20%	40% 40%
Behavioral Health Services: Mental Health and Substance Abuse (1)(limits and maximums apply) <ul style="list-style-type: none"> Inpatient Facility Services Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Autism: \$500 monthly maximum for children age 2 - 21	20% 20%/20% 20%	40% 40% 40%
Human Organ and Tissue Transplants <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	20%	40%
Prescription Drugs: <ul style="list-style-type: none"> Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (90-day Supply) Includes diabetic test strip 	20% 20%	40% (2) Not Covered
Lifetime Maximum (Combined Network and Non-Network) (3)	\$5 million	\$5 million

Notes:

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance including prescription drugs.
- Network and Non-network deductibles are combined. Network and Non-network coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to the end of the calendar year in which the child attains age 19; or to the end of the calendar year in which the child attains age 24 if the child qualifies as a full-time student.
- 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. No cost share means no deductible or coinsurance up to the maximum allowable amount.
- 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
- (1) We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.
- (2) Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- (3) Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

Precertification:

- Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

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Pre-Existing Exclusion Period:

We will not provide benefits for services, supplies, or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical), which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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.
