

# Your Summary of Benefits

## Lumenos HSA Plans



### Small Group Lumenos HSA 3500 (80/50) Plan

Effective 10/2011

**This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.**

This Lumenos plan is an innovative type of coverage that allows a member to use a Health Savings Account (HSA) to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan, that protects the member against large medical expenses. The member can spend the money in the HSA account the way the member wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the member may have to pay in the future. If covered expenses exceed the member's available HSA dollars, the traditional health coverage is available after an out-of-pocket amount is paid by the member.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the certificate or EOC.

#### Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

**Participating Providers-** The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

**Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)**-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount. Non-participating hospitals are covered at a reduced benefit but there are no benefits for care in non-contracting hospitals, except for medical emergencies. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the Reasonable and Customary Value. Members will not be responsible for any amount in excess of the Reasonable and Customary Value.

**Participating Pharmacies & Mail Service Program**-members are not responsible for any amount in excess of the prescription drug maximum allowed amount. **Non-Participating Pharmacies**-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount.

**Calendar Year Deductible** (*In-network/out-of-network deductibles are exclusive of each other; applicable to medical care & prescription drug benefits; family deductible includes employee & one or more enrolled family members, no coverage may be paid for any family member unless the family deductible is met*)

- Participating Providers, Participating Pharmacy & Other Health Care Providers \$3,500/member; \$7,000/family<sup>f</sup>
- Non-Participating Providers & Non-Participating Pharmacy \$3,500/member; \$7,000/family<sup>f</sup>

**Annual Out-of-Pocket Maximums** (*in-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug covered expense*)

- Participating Providers, Participating Pharmacy & Other Health Care Providers \$5,000/member; \$10,000/family<sup>f</sup>
- Non-Participating Providers & Non-Participating Pharmacy \$10,000/member; \$20,000/family<sup>f</sup>

The following do not apply to out-of-pocket maximums: costs in excess of the covered expense & non-covered expense, amounts paid for services rendered by non-participating providers for acupuncture/acupressure and mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child). After an individual or family member reaches the out-of-pocket maximum for all medical and prescription drug covered expense during a calendar year, the member will no longer be required to pay a copay for the remainder of that year, except as stated in the Certificate or EOC. The member remains responsible for costs in excess of the covered expense.

**Lifetime Maximum** Unlimited

**Traditional Health Coverage**  
Member Copay after Calendar Year Deductible (*unless as stated otherwise*)

Covered Services	In-Network	Out-of-Network <sup>SS</sup>
<b>Preventive Care</b> Preventive Care Services including*, physical exams, preventive screenings ( <i>including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision</i> ), immunizations,		

Covered Services	In-Network	Out-of-Network <sup>SS</sup>
health education, intervention services and HIV testing *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	50%
<b>Physician Medical Services</b> <ul style="list-style-type: none"> <li>Office &amp; home visits (<i>includes retail health clinic &amp; online clinic visit</i>)</li> <li>Hospital &amp; skilled nursing facility visits</li> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthesiologist</li> </ul>	20%  20% 20%	50%  50% 50%
<b>Physical Therapy, Physical Medicine &amp; Occupational Therapy, including Chiropractic Services</b> ( <i>limited to 24 visits/calendar year</i> )	20%	50% ( <i>benefit limited to \$25/visit</i> )
<b>Acupuncture/Acupressure</b> <ul style="list-style-type: none"> <li>Services for the treatment of disease, illness or injury (<i>limited to \$30/visit &amp; 24 visits/calendar year</i>)</li> </ul>	20%	50% <sup>††</sup>
<b>Diagnostic X-Ray &amp; Lab</b>	20%	50%
<b>Advanced Imaging</b> ( <i>pre-service review required</i> )	20%	50% ( <i>benefit limited to \$800/procedure</i> )
<b>Urgent Care</b> ( <i>physician services</i> )	20%	50%
<b>Emergency Care</b> <ul style="list-style-type: none"> <li>Emergency room services &amp; supplies</li> <li>Physician services</li> </ul>	20%  20%	20%  20%
<b>Hospital Medical Services</b> ( <i>pre-service review required for inpatient and certain outpatient services; waived for emergency admissions</i> ) <ul style="list-style-type: none"> <li>Semi-private room, meals &amp; special diets, &amp; ancillary services</li> <li>Outpatient medical care, surgical services &amp; supplies (<i>hospital care other than emergency room care</i>)</li> </ul>	20%  20%	50% ( <i>benefit limited to \$650/day</i> ) 50% ( <i>benefit limited to \$380/admit</i> )
<b>Skilled Nursing Facility</b> ( <i>pre-service review required</i> ) <ul style="list-style-type: none"> <li>Semi-private room, services &amp; supplies (<i>limited to 100 days/ calendar year</i>)</li> </ul>	20%	50% ( <i>benefit limited to \$150/day</i> )
<b>Ambulance</b> <ul style="list-style-type: none"> <li>Ground or air ambulance transportation, services &amp; disposable supplies (<i>air ambulance in a non-medical emergency is subject to</i></li> </ul>	20%	In an emergency or with an authorized referral: 20%

Covered Services	In-Network	Out-of-Network <sup>SS</sup>
<i>utilization review)</i>		Non-emergency or no referral: 50%
<b>Ambulatory Surgical Centers</b> ( <i>pre-service review required for certain surgeries</i> ) <ul style="list-style-type: none"> <li>Outpatient surgery, services &amp; supplies</li> </ul>	20%	50% ( <i>benefit limited to \$380/admit</i> )
<b>Pregnancy &amp; Maternity Care</b> <ul style="list-style-type: none"> <li>Physician office visits</li> </ul> <p>Normal delivery, cesarean section, complications of pregnancy &amp; abortion (<i>newborn routine nursery care covered when natural mother is insured employee or spouse/domestic partner</i>). Refer to the Physician &amp; Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.</p>	20%	50%
<b>Infertility Services</b> ( <i>limited to \$2,000/lifetime benefit</i> ) <sup>S</sup>	20%	50%
<b>Mental or Nervous Disorders and Substance Abuse<sup>T</sup></b> <ul style="list-style-type: none"> <li>Facility-based care (<i>pre-service review required; limited to 30 days per year, in and out of network combined</i>)</li> <li>Professional services (<i>One visit per day, 20 visits per year, in network and out of network combined; pre-service review required after the 12th visit</i>)</li> </ul>	20%	50% ( <i>benefit limited to \$175/day</i> ) <sup>TT</sup>
<b>Durable Medical Equipment</b> ( <i>pre-service review may be required</i> ) <ul style="list-style-type: none"> <li>Rental or purchase of DME</li> </ul>	50%	50%
<b>Home Health Care</b> ( <i>pre-service review required</i> ) <ul style="list-style-type: none"> <li>Services &amp; supplies from a home health agency (<i>limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less</i>)</li> </ul>	20%	50% ( <i>benefit limited to \$75/visit</i> )
<b>Infusion Therapy</b> ( <i>pre-service review required</i> ) <sup>S</sup> <ul style="list-style-type: none"> <li>Includes chemotherapy</li> </ul>	20%	50% ( <i>benefit limited to \$50/day for expenses except drugs; combined plan payment limited to \$500/day</i> )
<b>Outpatient Prescription Drug Benefits</b> ( <i>Until the calendar year deductible is satisfied, the member pays the prescription drug covered expense, and not the copays listed below.</i> ) Your copay is determined by whether it is tier 1, tier 2, tier 3 or tier 4 drug. To determine tier status, the tiered drug formulary list is furnished to your provider and is also available online at <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> , click on Customer Care, Download Forms and then choose Anthem Blue Cross Drug List (tiered). You may also contact our pharmacy customer service at 800-700-2533.		
<b>Retail Participating Pharmacy</b> ( <i>30-day supply</i> ) <sup>T</sup> <ul style="list-style-type: none"> <li>Preventive immunizations administered by a retail pharmacy</li> </ul>	No copay ( <i>deductible waived</i> )	

Covered Services	In-Network	Out-of-Network <sup>SS</sup>
<ul style="list-style-type: none"> <li>• Tier 1 drugs</li> <li>• Tier 2 drugs (<i>includes diabetic supplies</i>)</li> <li>• Tier 3 drugs (<i>includes compound drugs</i>)</li> </ul> <b>Non-Participating Pharmacies (30-day supply)<sup>†</sup></b>	\$10 \$30 <sup>ff</sup> \$50 <sup>ff</sup>	50% of the prescription drug maximum allowed plus excess charges
<b>Mail Service (90-day supply)<sup>†</sup></b> <ul style="list-style-type: none"> <li>• Tier 1 drugs</li> <li>• Tier 2 drugs (<i>includes diabetic supplies</i>)</li> <li>• Tier 3 drugs<sup>‡</sup></li> </ul>	\$10 \$60 <sup>ff</sup> \$100 <sup>ff</sup>	
<b>Specialty pharmacy drugs (May only be obtained through the specialty pharmacy program)</b> <ul style="list-style-type: none"> <li>• Tier 4 drugs</li> </ul>	30% of prescription drug maximum allowed amount	

**Additional information about your outpatient prescription drug benefits:**

- Preventive flu and pneumonia vaccines administered by a participating retail pharmacy.
- Outpatient Drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Insulin. Insulin syringes prescribed and dispensed for use with Insulin.
- Lancets and test strips for use in monitoring diabetes.
- Non-infused compound Prescriptions which contain at least one covered Prescription ingredient may be limited to distribution at designated Participating Pharmacies.
- Oral contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Drugs and medications prescribed for the treatment of Infertility limited to a lifetime maximum payment of \$1,500 per member. If such medications are classified as Specialty Drugs, they may be subject to the Specialty Pharmacy Program.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance by Anthem Blue Cross and are limited to 8 tablets/units per 30 day period. (Not covered under the mail service prescription drug program.)
- Phenylketonuria (PKU) formulas and special food products to treat PKU that are listed on the Formulary and obtained from a Pharmacy.
- Classified specialty drugs must be obtained through the Specialty Pharmacy Program and are subject to the terms of the program.

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, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

- †** Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance or EOC for complete information.
- ‡** Does not apply to coverage of severe mental illness and serious emotional disturbances of a child, except pre-service review.
- §** Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
- f** Once one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.
- ††** The non-participating benefits do not apply toward the Annual Out-of-Pocket Maximum. Please see the Certificate or EOC for complete information.
- ‡‡** Compound drugs are not covered through mail service; only covered through certain retail participating pharmacies.
- SS** Member pays copay plus all charges in excess of the maximum allowed amount.
- ff** If a member selects a brand name drug when a generic drug substitution exists, even if the member's physician has specified "dispense as written" (DAW) or "do not substitute", the member will be responsible for tier 1 copay, plus the difference between the cost of the generic drug and the cost of the brand name drug.

## Lumenos Plan - Exclusions and Limitations

Following is an abbreviated list of exclusions and limitations; please see the Certificate for comprehensive details.

### Prescription Drug Exclusions & Limitations

Drugs and medications which may be obtained without a Physician's Prescription, except Insulin and Niacin for cholesterol lowering.

Prescription Drugs which have non-Prescription (over-the-counter) chemical and dosage equivalents. If a Drug is prescribed because the non-Prescription equivalent was tried and did not work, this exclusion does not apply.

Non-medicinal substances or items.

Any expense for a drug or medication incurred in excess of (a) the Drug Limited Fee Schedule for drugs dispensed by non-participating pharmacies; or (b) the outpatient prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program.

Pharmaceuticals to aid smoking cessation (e.g. Nicorette or nicotine patches), over the counter remedies, or any Prescription product containing nicotine except as specified as covered in the Certificate.

Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.

Drugs and medications used to induce non-spontaneous abortions.

Dietary supplements, herbs, vitamins, cosmetics, health or beauty aids, or similar products which are not FDA approved to diagnose, treat, cure or prevent a medical condition except for treatment of phenylketonuria.

Drugs furnished by a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.

Any Drug labeled Caution, limited by federal law to investigational use, non-FDA approved Investigational drugs or any drug or medication prescribed for Experimental indications.

Syringes and/or needles, except those dispensed for use with Insulin.

Durable medical equipment, devices, appliances, and supplies, except lancets and test strips for use in monitoring diabetes.

Immunizing agents, biological sera, blood, blood products or blood plasma.

Oxygen.

Professional charges in connection with administering, injecting or dispensing Drugs.

Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities and doctors' offices.

Drugs when used for cosmetic purposes.

Drugs when used for the primary purpose of treating Infertility in excess of the lifetime maximum.

Drugs used for weight loss, except for the Medically Necessary treatment of morbid obesity.

Drugs obtained outside the United States.

Allergy desensitization products, allergy serum.

All Infusion Therapy, except self-administered injectables and aerosols.

Treatment of impotence and/or sexual dysfunction except as specified as covered in the Certificate.

Replacement of Drugs and medications when lost, stolen or damaged.

A prescription dispensed in excess of a 30-day supply (unless ordered by mail through the mail service drug program, in which case the limit is 90-day supply).

Compound medications obtained from other than a participating pharmacy.

Classified specialty drugs that must be obtained through our Specialty Pharmacy Program and are instead obtained from a retail pharmacy.

### Medical Exclusions and Limitations

Any amounts in excess of maximums stated in the Certificate

Services or supplies that are not medically necessary

Services received before your effective date

Services received after your coverage ends

Any conditions for which benefits can be recovered under any workers' compensation law or similar law

Services you receive for which you are not legally obligated to pay

Services for which no charge is made to you in the absence of insurance coverage

Services not listed as covered in the Certificate

Services from relatives

Vision care except as specifically stated in the Certificate

Eye surgery performed solely for the purpose of correcting refractive defects

Hearing aids. Routine hearing tests except as specifically stated in the Certificate

Sex changes

Dental and orthodontic services except as specifically stated in the Certificate

Cosmetic surgery

Routine physical examinations except as specifically stated in the Certificate

Treatment of mental or nervous disorders and substance abuse (including nicotine use) or psychological testing, except as specifically stated in the Certificate

Custodial care

Experimental or investigational services

Services provided by a local, state or federal government agency, unless you have to pay for them

Diagnostic admissions

Telephone or facsimile machine consultations

Personal comfort items

Nutritional counseling

Health club memberships

Commercial weight loss programs

Medical supplies and equipment/durable medical equipment, except as specifically stated in the Certificate

Specialty drugs, except as specifically stated in the Certificate

Any services to the extent you are entitled to receive Medicare benefits for those services without payment of additional premium for Medicare coverage

Food or dietary supplements, except as specifically stated in the Certificate or as required by law

Genetic testing for non-medical reasons or when there is no medical indication or no family history of genetic abnormality

Outdoor treatment programs

Replacement of prosthetics and durable medical equipment when lost or stolen

Any services or supplies provided to any person not covered under the Agreement in connection with a surrogate pregnancy

Immunizations solely for travel outside the United States

Services or supplies related to a pre-existing condition

Educational services except as specifically provided or arranged by Anthem Blue Cross

Infertility services (including sterilization reversal) except as specifically stated in the Certificate

Care or treatment provided in a non-contracting hospital

Private duty nursing except as specifically stated in the Certificate

Services primarily for weight reduction except medically necessary treatment of morbid obesity

Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting

Contraceptive devices unless your physician determines that oral contraceptive drugs are not medically appropriate.

Vein Treatment: Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

**Third Party Liability** - Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

**Coordination of Benefits** - The benefits of this plan may be reduced if the member has any other group health, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense.