Lumenos Health Savings Account (HSA)

Outline of Coverage – Major Medical Expense

Underwritten by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven Connecticut 06473 · 1-866-279-9911

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

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

A Brief Description of Benefits

Covered Service	In-Network Services (*Out-of-Network Services)			
Single Deductible*	$1,250	$2,500	$2,500	$5,000
Family Deductible**	$2,500	$5,000	$5,000	$10,000
Member In-Network Coinsurance	N/A	20%	N/A	N/A
(Member Out-of-Network Coinsurance)	(30%)	(40%)	(30%)	(30%)
Member Out-of-pocket Limit				
Single	$1,250 ($2,500)	$5,000 ($10,000)	$2,500 ($5,000)	$5,000 ($10,000)
Family	$2,500 ($5,000)	$10,000 ($20,000)	$5,000 ($10,000)	$10,000 ($20,000)
Lifetime Maximum	Unlimited ($1,000,000)			

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

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

Note: The Deductible may be prorated for Members who begin or change to coverage under this Subscriber Agreement at any time other than at the beginning of the benefit period. Single Out of Pocket Limit – Once the Member Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member for the remainder of the benefit period except for Out of Network Human Organ and Tissue Transplant services. Family Out of Pocket Limit - Once the family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the benefit period except for Out-of -Network Human Organ and Tissue Transplant services. In Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate toward each other.

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

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Covered Service	In-Network Services (*Out-of-Network Services)
Mental Health and Substance Abuse Services	
Outpatient Treatment for Mental Health Care and Substance Abuse Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Inpatient Hospital Services *In a Hospital or Residential Treatment Center for Mental Health Care*	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Inpatient Rehabilitation Treatment for Substance Abuse Care *In a Hospital or Substance Abuse Treatment Facility*	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Miscellaneous Hospital Services	
Emergency Room Treatment	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Urgent Care Services	Deductible and In-Network Coinsurance (Paid as an In-Network Emergency Room)
Surgical Services	
Outpatient surgery *In a licensed ambulatory surgical center*	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Medical Office Visit	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
In-Hospital Medical Services	
Services of a Physician or Surgeon *(other than a medical office visit)*	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Out-of-Hospital Care	
Well Child Care	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Adult Physical Examinations	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Other Preventive Screenings *Including but not limited to:* · *Routine gynecological care: pap smear and pelvic exam* · *Mammography screening* · *Flexible sigmoidoscopy* · *Total Cholesterol screening* · *Diabetic screening* · *Prostate screening* · *Colorectal Cancer screening* · *Colonoscopy* · *Lipid screening and panels*	No Cost Share In-Network (Deductible and Out-of-Network Coinsurance)
Other Benefits	
Immunizations and Vaccinations *(other than those needed for travel)*	No Cost Share (Deductible and Out-of-Network Coinsurance)
Immunizations and Vaccinations for Travel	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Prescription Drugs *The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30-day supply* *Diabetic drugs and supplies*	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Diagnostic Services *(Diagnostic, Laboratory, X-ray, MRI, MRA, CAT, CTA, PET and SPECT)*	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

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

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

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.
The $2,500/$5,000 deductible plan with the 20% member in-network coinsurance is the only plan that has in-network coinsurance.

A Prescription Drug Program to Help Keep Costs Down

If you enroll in BlueCare Direct (HMO), you'll automatically get prescription drug coverage under a three-tier program.

If you enroll in Century Preferred Direct (PPO), you'll have the option of also purchasing the three-tier Prescription Drug Program. If you decide to not purchase this coverage, you'll have access to the ScriptSave discount program.

If you enroll in a Lumenos plan, prescriptions can be paid for with funds from your HSA, HIA or HIA Plus account, and then through the traditional PPO coverage, once it kicks in. At all times, you can always save money by:

- Using pharmacies in the Anthem network
- Using generic medications (when they are available)
- Using the online mail order pharmacy

The Three-Tier Drug Program

This prescription drug program gives you access to the medications you need to stay healthy. There are three levels of copayments for prescriptions. The amount of your copay depends on the tier in which the drug falls.

Tier 1 (lowest level copayment)... for most generic medications—Your prescription cost share will usually be lowest when you purchase a generic drug.

Tier 2 (mid-level copayment)... for medications on the Anthem Formulary—Your copayment is higher than for drugs on Tier 1, but less than medications not on the Anthem Formulary (Tier 3).

Tier 3 (highest level copayment)... for medications not included on the Anthem Formulary—You have coverage for non-formulary prescription drugs, but your out-of-pocket costs will be higher than for medications on the formulary.

What is the Anthem Formulary?

An important way that we contribute to the overall quality of your health coverage is by maintaining a drug list called a formulary. This list is created and managed by a committee of practicing physicians and pharmacists The committee meets periodically to review and update the formulary based on findings in pharmaceutical research and the medical community. You and your doctor can search the Anthem Formulary at anthem.com.

The pharmacy down the street is probably in the network.

As part of your prescription drug benefits, you'll have access to more than 50,000 chain and independent pharmacies across the country.

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Don’t feel like driving to the pharmacy? Use the Anthem Rx Direct Mail Service

If you choose, you can purchase your prescription drugs through Anthem Rx Direct. Prescriptions are filled promptly, checked for safety and accuracy by registered pharmacists and delivered to your home in confidential, secure packaging. Depending on your drug benefits and the particular medication prescribed by the doctor, you may be able to order up to a 90-day supply of your medication at a reduced copayment. You can quickly order refills by calling a toll-free number or at anthem.com.

ScriptSave (for Century Preferred Direct & Lumenos Members)

All Century Preferred Direct members who do not elect to add prescription drug coverage are eligible to take advantage of our ScriptSave pharmacy discount program. The ScriptSave Prescription Drug Discount Program is available without any enrollment or monthly fees. There’s also no waiting period. It provides discounts on prescriptions filled at any of ScriptSave’s participating pharmacies. Please note that ScriptSave is not available to BlueCare Direct members.

ScriptSave, administered by The Medical Security Card Company, Inc. of Tucson, Arizona, is a value added service for certain Anthem Blue Cross and Blue Shield health plans that do not have a prescription drug benefit.
The ScriptSave Prescription Drug Discount Card is not an insurance policy or benefit, and does not provide insurance coverage. The ScriptSave program may be discontinued at any time. BlueCare Direct members are not eligible for the ScriptSave program.