

CONSUMER DIRECTED PLANS SUMMARY OF BENEFITS

	Lumenos HSA 1800*		Lumenos HSA 2500*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (Individual/Family aggregate)	\$1,800 ind./\$3,600 fam. ¹ (medical and pharmacy combined)	\$1,800 ind./\$3,600 fam. ¹ (medical and pharmacy combined)	\$2,500 ind./\$5,000 fam. ¹ (medical and pharmacy combined)	\$2,500 ind./\$5,000 fam. ¹ (medical and pharmacy combined)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Physician Services — Out-Patient				
Office visit/consultations (not including routine exams)	80%	50%	80%	50%
Specialist visits and consultations	80%	50%	80%	50%
Laboratory, x-rays, diagnostics	80%	50% (Max \$800 benefit for Advanced Imaging)	80%	50% (Max \$800 benefit for Advanced Imaging)
Physician Services — In-Patient				
In-Patient visits and consultations	80%	50%	80%	50%
Surgeons and assistants, anesthesiologists, pathologists, radiologists	80%	50%	80%	50%
Preventive Benefits				
Annual Routine Physical Exam (one per calendar year) <i>See Plan's Certificate for details of covered benefits</i>	100% (ded. waived)	50%	100% (ded. waived)	50%
Hospital Services — Out-Patient				
Out-Patient surgery • Renal dialysis	80%	50% (Up to \$380 per admission) ⁵	80%	50% (Up to \$380 per admission) ⁵
Hospital Pre-Authorization	Required			
Hospital Services — In-Patient				
Semi-private room and board, medically necessary services and supplies, including subacute care	80%	50% (Up to \$650 per day) ⁵	80%	50% (Up to \$650 per day) ⁵
Hospital Pre-Authorization	Required			
Pregnancy & Maternity Care				
Prenatal and postnatal care	80%	50%	80%	50%
All necessary In-Patient hospital services	Covered under In-Patient Hospital			
Emergency Services	\$150 (waived if admitted)-80%	\$150 (waived if admitted)-80%	\$150 (waived if admitted)-80%	\$150 (waived if admitted)-80%
Ambulance	80%	50%	80%	50%
Physical, Occupational Therapy and Chiropractic Care	80%	50% (Up to \$25 per visit) ⁵	80%	50% (Up to \$25 per visit) ⁵
	Maximum 24 visits per year			

Note: For non-emergency care, out-of-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 is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value. Plans exclude coverage for pre-existing conditions (except for members under age 19, a child acquired through legal guardianship if the child is added within 31 days of final court decree or order, a child born to or newly adopted by an enrolled subscriber or spouse, or conditions of pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

* HSA-Qualified High Deductible Health Plan.

¹ Employees enrolling for single coverage must satisfy the single deductible; for employees enrolling with Dependent coverage, the family deductible must be met before any member receives benefits.

² If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug.

³ Pre-service review is required for the following mental or nervous disorders and substance abuse services: 1) Facility-based treatment; and 2) Out-Patient professional services after twelve visits.

⁴ The following do not apply to the out-of-pocket maximum: charges paid for acupuncture/acupressure by non-participating providers and non-covered expenses. The insured remains responsible for these amounts even after the out-of-pocket maximum has been met.

⁵ The coverage amount listed is the maximum allowed charge for non-emergency services received from a non-participating hospital or non-participating provider. Members are responsible for all charges in excess of the covered amount. Physician Services are covered separately at 50% of Allowable Amounts.

⁶ Our reimbursement within the state of California is listed. Members are responsible for all charges in excess of the maximum allowed amount. The submission of a prescription drug claim is required for reimbursement of out-of-network pharmacies.

Note: 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).

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	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment	50%	50%	50%	50%
Drug & Alcohol Benefits, Mental & Nervous Benefits³ <i>(severe and non-severe)</i>				
Out-Patient	80%	50%	80%	50%
In-Patient	80%	50% (Up to \$650 per day) ⁵	80%	50% (Up to \$650 per day) ⁵
Hospice – Routine Home Care	80%	50%	80%	50%
Home Health Care	80%	50% (Up to \$75 per visit) ⁵	80%	50% (Up to \$75 per visit) ⁵
	Maximum 100 visits per year			
Skilled Nursing Facility	80%	50% (Up to \$150 per day) ⁵	80%	50% (Up to \$150 per day) ⁵
	Maximum 100 days per year			
Acupuncture	80% (up to \$30 per visit)	50% (Up to \$30 per visit) ⁵	80% (up to \$30 per visit)	50% (Up to \$30 per visit) ⁵
	Maximum 24 visits per year			
Infertility Evaluation and Treatment	80%	50%	80%	50%
	\$2,000 Maximum Lifetime Benefit		\$2,000 Maximum Lifetime Benefit	
Out-of-Pocket Maximum⁴ (Individual/Family) <i>Includes Plan Deductible and Pharmacy covered expenses</i>	\$3,000/\$5,500	\$3,000/\$5,500	\$4,000/\$6,000	\$4,000/\$6,000
Prescription Costs	Participating Pharmacy		Non-Participating Pharmacy	Mail Service Prescriptions
Out-Patient Drugs ² <i>(subject to medical deductible, includes oral contraceptives)</i>				For up to a 90 day supply
Generic Drugs	\$15		50% of maximum allowed amount ⁶	\$15
Formulary Drugs	\$30		50% of maximum allowed amount ⁶	\$60
Non-Formulary Drugs	\$50		50% of maximum allowed amount ⁶	\$100

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