Your Summary of Benefits
Lumenos HSA 80/50 Plans

Small Group Lumenos HSA 3500 (80/50) Plan
Effective **10/2010**

This Lumenos plan is an innovative type of coverage that allows an insured to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan that protects the insured against large medical expenses. Separate from the health plan, a Health Savings Account (HSA) is a convenient, optional way for an insured to pay for health care expenses on a tax-favored basis. Insureds can sign up for an HSA and, with the help of a tax advisor, avail of the benefits of a health plan and financial strategy, all in one. The insureds can spend the money in the HSA account for 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 insured may have to pay in the future. If covered expenses exceed the insureds available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the insured. The insured is 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 Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

Participating Providers - PPO-negotiated rates. Insureds are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-Participating Providers & Other Eligible Health Care Providers (*includes those not represented in the PPO provider network*) - The allowed amount for professional services and institutional services. For Special Circumstances and Other Eligible Health Care Providers, including emergency care - the customary & reasonable charge for professional services or the reasonable charge for institutional services.

Participating Pharmacies & Mail Service Program - Prescription drug negotiated rates. Insureds are not responsible for any amount in excess of the prescription drug negotiated rate.

Non-Participating Pharmacies - Drug limited fee schedule amount. Insureds are responsible for any expense not covered under this plan & any amount in excess of drug limited fee schedule amount.

When using non-participating providers and other eligible health care providers, the insured is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay. When using the outpatient prescription drug benefits, the insured is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible for all providers (*applicable to medical care and prescription drug benefits*)	
Individual insured	$3,500/insured
Insured family (*includes insured employee & one or more members of the employee's family; no coverage may be paid for any family member unless this $7,000 deductible is met*)	$7,000/family aggregate††
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 Eligible Health Care Providers	$5,000/insured; $10,000/family aggregate††
• Non-Participating Providers & Non-Participating Pharmacy	$10,000/insured; $20,000/family aggregate††

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 insured reaches the out-of-pocket maximum for all medical and prescription drug covered expense during a calendar year, the insured will no longer be required to pay a copay for the remainder of that year, except as stated in the Certificate. The insured remains responsible for costs in excess of the covered expense when provided by non-participating providers and other eligible health care providers; non-covered expense, and copays 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).

Lifetime Maximum	Unlimited

Traditional Health Coverage

Insured Copay after Calendar Year Deductible (*unless as stated otherwise*)

Covered Services	In-Network	Out-of-Network
Preventive Care[ff] *Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits*		
• Routine physical exams, immunizations, diagnostic x-ray & lab for routine physical exam	No copay *(deductible waived)*	50%[f]
• Adult Preventive Services *(including mammograms, pap smears, prostate & colorectal cancer screenings)*	No copay *(deductible waived)*	50%[f]
Physician Medical Services		
• Office & home visits	20%	50%[f]
• Hospital & skilled nursing facility visits	20%	50%[f]
• Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	50%[f]
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services (*limited to 24 visits/calendar year*)	20%	All charges except $25/visit
Acupuncture/Acupressure		
• Services for the treatment of disease, illness or injury (*limited to 24 visits/calendar year*)	All charges except $30/visit	All charges except $30/visit[‡‡]
Diagnostic X-Ray & Lab (*pre-service review required for certain diagnostic procedures*)	20%	50%[f]
Emergency Care		
• Emergency room services & supplies	20%	20% of C&R, plus 100% of excess charges
• Inpatient hospital services & supplies	20%	20% of C&R, plus 100% of excess charges
• Physician services	20%	20% of C&R, plus 100% of excess charges
Hospital Medical Services (*pre-service review required for inpatient services; waived for emergency admissions*)		
• Semi-private room, meals & special diets, & ancillary services	20%	All charges in excess of $650/day
• Outpatient medical care, surgical services & supplies (*hospital care other than emergency room care*)	20%	All charges in excess of $380/day
Skilled Nursing Facility (*pre-service review required*)		
• Semi-private room, services & supplies (*limited to 100 days/ calendar year*)	20%	All charges in excess of $150/day
Ambulance		
• Ground or air ambulance transportation, services & disposable supplies	20%	In an emergency or with an authorized referral: 20% of customary & reasonable (C&R), plus 100% of excess charges Non-emergency or no referral: 50%[f]
Ambulatory Surgical Centers (*pre-service review required*)		
• Outpatient surgery, services & supplies	20%	All charges in excess of $380/day
Pregnancy & Maternity Care		
• Physician office visits	20%	50%[f]
Normal delivery, cesarean section, complications of pregnancy & abortion (*newborn routine nursery care covered when natural mother is insured employee or spouse/domestic partner*)		

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Covered Services	In-Network	Out-of-Network
• Inpatient physician services	20%	50%[f]
• Hospital & ancillary services	20%	50%[f]
Infertility Services (*limited to $2,000/lifetime benefit*)[§]	20%	50%[f]
Mental or Nervous Disorders and Substance Abuse[‡]		
• Facility-based care (*pre-service review required; limited to 30 days per year, in and out of network combined*)	All of negotiated fee except $175 per day	All charges in excess of $175 per day[‡‡]
• Professional services (*One visit per day, 20 visits per year, in network and out of network combined; pre-service review required after the 12th visit*)	All of negotiated fee except $25 per visit	All charges in excess of $25 per visit[‡‡]
Home Health Care (*pre-service review required*)		
• Services & supplies from a home health agency (*limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care*)	20%	All charges except $75/visit
Infusion Therapy (*pre-service review required*)[§]		
• Includes chemotherapy	20%	All charges in excess of $50/day for expenses except drugs; all charges over wholesale cost of infusion therapy drugs; (combined plan payment limit $500/day)
Prescription Drugs ***(subject to calendar year deductible)***		
Participating Retail Pharmacy (30-day supply[†])		
• Generic	$10 copay	
• Brand name drugs[§§]	$30 copay for formulary; $50 copay for non-formulary	
• Self-administered injectable drugs (*except insulin*)	30% of negotiated fee	
Non-participating Pharmacies (30-day supply)[†]		50% of the drug limited fee schedule plus 100% of excess charges
Mail Service (90-day supply)[†]		
• Generic	$10 copay	
• Brand name drugs[§§]	$60 copay for formulary; $100 copay for non-formulary	

Additional information about your outpatient prescription drug benefits:

- 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 Insured. 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 is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan in detail.
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 Evidence of Coverage and Disclosure form (EOC) or Certificate of Insurance 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 Plus all charges in excess of Negotiated Fee Rate.

†† 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 for complete information.

§§ If an insured person selects a brand name drug when a generic drug substitution exists, even if the insured person's physician has specified "dispense as written" (DAW) or "do not substitute", the insured person will be responsible for generic copay, plus the difference between the cost of the generic drug and the cost of the brand name drug.

ff Age and frequency limitations may apply. When applicable, each family member ages 7 - adult may choose annually between the physical exam and the HealthyCheck screening.

Outpatient prescription drug services and supplies are not provided for or in connection with the following:

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.

Small Group Lumenos HSA 3500 (80/50) Plan - Exclusions and Limitations

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

Pre-Existing Condition Exclusion - No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the insured person's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled employee or spouse/domestic partner, or to conditions of pregnancy. Also if an insured person was covered under creditable coverage, as outlined in the insured person's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

Third Party Liability - Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Coordination of Benefits - The benefits of this plan may be reduced if the insured person 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.

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