

Lumenos HSA Option GHSA478

In-Network Services	You Pay	
Preventive Care Services		
<p>Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.</p> <p>* During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.</p>	No charge*	
Routine Vision		
<ul style="list-style-type: none"> ○ annual routine eye exam <li style="padding-left: 20px;"><i>Plus – valuable discounts on eyewear</i> <p>If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$3,000 deductible) and you will pay the rest of what the professional charges.</p>	\$15 for each visit	
Annual Deductible		
<p>Your deductible is combined for In-network and Out-of-Network services.</p> <ul style="list-style-type: none"> ○ For single coverage, you will pay all the costs associated with your care until you have paid \$3,000 in one calendar or plan year. ○ If two people are covered under your plan, each of you will pay the first \$3,000 of the cost of your care (\$6,000 total). ○ If three or more people are covered under your plan, together you will pay the first \$6000 of the cost of your care. However, the most one family member will pay is \$3,000. <p>In-Network Services Once you have reached this amount, you will pay the amounts designated in the “you pay” column below.</p> <p>Out-of-Network Services For covered services to out-of-network providers, you will pay 20%. However, it’s important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts.</p>		
Once you reach your deductible, you will pay the following for covered in-network services		
All Other In-Network Services		
Doctor Visits		
<ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ pre- and postnatal office visits ○ mental health and substance use visits ○ in-office surgery * <i>Limit does not apply to Autism Spectrum Disorder.</i> 	<ul style="list-style-type: none"> ○ physical and occupational therapy in an office setting (30 combined visits)* ○ speech therapy visits in an office setting (30 visit limit)* ○ spinal manipulations and other manual medical intervention visits (30 visit limit) 	0% of the amount the health care professionals in our network have agreed to accept for their services
Labs, Diagnostic X-rays and Other Outpatient Services		
<ul style="list-style-type: none"> ○ diagnostic lab services ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy 	<ul style="list-style-type: none"> ○ diagnostic x-rays ○ dialysis ○ ambulance travel ○ durable medical equipment 	0% of the amount the health care professionals in our network have agreed to accept for their services

In-Network Services	You Pay
<ul style="list-style-type: none"> diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
<ul style="list-style-type: none"> diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> behavioral health treatment* pharmacy care psychiatric care psychological care therapeutic care** <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> applied behavioral analysis <ul style="list-style-type: none"> limited to a \$35,000 per member annual maximum 	0% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
<ul style="list-style-type: none"> unlimited per member per calendar year up to age 3 	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
<ul style="list-style-type: none"> physical therapy and occupational therapy (30 combined visits)* speech therapy (30 visit limit)* surgery emergency room physician services mental health and substance use partial-day treatment programs <p>* Limit does not apply to Autism Spectrum Disorder.</p>	0% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
<ul style="list-style-type: none"> home health care (100 visits) private duty nursing is limited to 16 hours per member per calendar year* <p>*Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.</p>	0% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> hospice care 	0% of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> semi-private room, intensive care or similar unit physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services skilled nursing facility care (100 days for each admission) 	0% of the amount the health care professionals in our network have agreed to accept for their services
Retail Pharmacy	
<ul style="list-style-type: none"> Up to a 30-day medication supply at participating pharmacies (tier will be based on the type of prescription drug received) 	Tier 1 \$10 Tier 2 \$30 Tier 3 \$50 Tier 4 20% up to \$200/script
Mail order Pharmacy	
<ul style="list-style-type: none"> Up to a 90-day medication supply delivered to your home (tier will be based on the type of prescription drug received) 	Tier 1 \$25 Tier 2 \$75 Tier 3 \$125 Tier 4 N/A
Retail Maintenance	
<ul style="list-style-type: none"> Up to a 90-day medication supply at participating pharmacies 	Tier 1 \$30 Tier 2 \$90 Tier 3 \$150 Tier 4 N/A

Your benefit period may be a calendar year or a plan year. A calendar year means your benefit period runs from January through December while a plan year runs from the effective date of the plan through a 12-month period (e.g. February 1 through January 31 or July 1 through June 30). Check with your employer to learn whether your benefits will be calculated on a calendar year or plan year basis.

For benefits listed with specific limits all services received in the calendar year or plan year for that benefit are applied to that limit (whether received in or out of network).

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar or Plan Year

When using network professionals

For single coverage, you will pay \$4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$4,000 (\$8,000 total).
- If three or more people are covered under your plan, together you will pay \$8,000. However, no family member will pay more than \$4,000 toward the limit.

When not using network professionals

For single coverage, you will pay \$6,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$6,000 (\$12,000 total).
- If three or more people are covered under your plan, together you will pay \$12,000. However, no family member will pay more than \$6000 toward the limit.

The following do not count toward the calendar year out-of-pocket maximum:

- your share of the cost of adult routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your benefits
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

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.