# Anthem BlueCross BlueShield
# Lumenos HSA Plus

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2013 - 01/01/2014**

**Coverage For:** Individual/Family | **Plan Type:** CDHP

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 800-930-7956 or www.medicoverage.com .

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1500** single / **$3000** family for In-Network Provider<br>**$1500** single / **$3000** family for Non-Network Provider<br>Does not apply to In-Network Preventive Care | You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.** |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes; In-Network Provider Single: **$4000**, Family: **$8000** Non-Network Provider Single: **$8000**, Family: **$16000** | The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Balance-Billed Charges, Health Care This Plan Doesn't Cover, Premiums. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the insurer pays?** | No. This policy has no overall annual limit on the amount it will pay each year. | The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See **www.anthem.com** or call **1-888-224-4902** for a list of participating providers. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network. |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **Do I need a referral to see a specialist?** | No, you do not need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network Provider** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a In-Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 40% coinsurance | 50% coinsurance | ————none———— |
| | Specialist visit | 40% coinsurance | 50% coinsurance | ————none———— |
| | Other practitioner office visit | Manipulative Therapy<br>40% coinsurance<br><br>Acupuncturist<br>Not covered | Manipulative Therapy<br>50% coinsurance<br>Acupuncturist<br>Not covered | Manipulative Therapy<br>Coverage is limited to a total of 20 visits, In-Network Provider and Non-Network Provider combined per year.<br>There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.<br>Manipulative Therapy visits count towards your Physical Therapy limit. |
| | Preventive care/screening/ immunizations | No charge | 50% coinsurance | ————none———— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab - Office<br>40% coinsurance<br>X-Ray - Office<br>40% coinsurance | Lab - Office<br>50% coinsurance<br>X-Ray - Office<br>50% coinsurance | ————none———— |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | 50% coinsurance | ————none———— |

| Common Medical Event | Services You May Need | Your Cost If You Use a In-Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.anthem.com/pharmacyinformation/ | Tier 1 – Generic Drugs | 40% coinsurance (retail and mail order) | 50% coinsurance (retail only) | Unless otherwise indicated all retail sales have a 30 day limit. Mail Service has a 90 day limit. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service. |
| | Tier 2 – Typically Preferred/Formulary Brand | 40% coinsurance (retail and mail order) | 50% coinsurance (retail only) | Unless otherwise indicated all retail sales have a 30 day limit. Mail Service has a 90 day limit. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service. |
| | Tier 3 – Typically Non-preferred/ non-Formulary Drugs | 40% coinsurance (retail and mail order) | 50% coinsurance (retail only) | Unless otherwise indicated all retail sales have a 30 day limit. Mail Service has a 90 day limit. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service. |
| | Tier 4 – Typically Specialty Drugs | 40% coinsurance (retail and mail order) | Not covered | Unless otherwise indicated all retail sales have a 30 day limit. Mail Service has a 90 day limit. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service. |
| **If you have outpatient Surgery** | Facility Fee (e.g., ambulatory surgery center) | 40% coinsurance | 50% coinsurance | ————none———— |
| | Physician/Surgeon Fees | 40% coinsurance | 50% coinsurance | ————none———— |
| **If you need immediate medical attention** | Emergency Room Services | 40% coinsurance | 40% coinsurance | ————none———— |
| | Emergency Medical Transportation | 40% coinsurance | 40% coinsurance | ————none———— |
| | Urgent Care | 40% coinsurance | 40% coinsurance | ————none———— |

| Common Medical Event | Services You May Need | Your Cost If You Use a In-Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility Fee (e.g., hospital room) | 40% coinsurance | 50% coinsurance | Physical Medicine and Rehabilitation (In-Network and Non-Network combined) limited to 40 days, includes Day Rehabilitation programs. |
| | Physician/surgeon fee | 40% coinsurance | 50% coinsurance | ————none———— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Mental/Behavioral Health Office Visit<br>40% coinsurance<br>Mental/Behavioral Health Facility Visit - Facility Charges<br>40% coinsurance | Mental/Behavioral Health Office Visit<br>50% coinsurance<br>Mental/Behavioral Health Facility Visit - Facility Charges<br>50% coinsurance | Mental/Behavioral Health Office Visit<br>There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. |
| | Mental/Behavioral health inpatient services | 40% coinsurance | 50% coinsurance | Coverage is limited to a total of 90 days, In-Network Provider and Non-Network Provider combined per year. |
| | Substance use disorder outpatient services | Substance Abuse Office Visit<br>40% coinsurance<br>Substance Abuse Facility Visit - Facility Charges<br>40% coinsurance | Substance Abuse Office Visit<br>50% coinsurance<br>Substance Abuse Facility Visit - Facility Charges<br>50% coinsurance | Substance Abuse Office Visit<br>Coverage is limited to 30 visits per year in an office setting and 30 visits per year in an outpatient facility. Combined In-Network and Non-Network. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. |
| | Substance use disorder inpatient services | 40% coinsurance | 50% coinsurance | Coverage is limited to a total of 21 days, In-Network Provider and Non-Network Provider combined per year. 10 episodes per lifetime inpatient and outpatient combined. 6 days/year detox maximum. See your Certificate for details. |
| **If you are pregnant** | Prenatal and postnatal care | Not covered | Not covered | ————none———— |
| | Delivery and all inpatient services | Not covered | Not covered | ————none———— |

| Common Medical Event | Services You May Need | Your Cost If You Use a In-Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home Health Care | 40% coinsurance | 50% coinsurance | Coverage is limited to a total of 60 visits, In-Network Provider and Non-Network Provider combined per year. |
| | Rehabilitation Services | 40% coinsurance | 50% coinsurance | Coverage is limited to 20 visits annual max Physical Therapy, 20 visits annual max Occupational Therapy. Speech Therapy is unlimited.<br>There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.<br>Manipulative Therapy visits count towards your Physical Therapy limit. |
| | Habilitation Services | 40% coinsurance | 50% coinsurance | Habilitation visits count towards your rehabilitation limit. |
| | Skilled Nursing Care | 40% coinsurance | 50% coinsurance | Coverage is limited to a total of 90 days, In-Network Provider and Non-Network Provider combined per year. |
| | Durable medical equipment | 40% coinsurance | 50% coinsurance | ————none———— |
| | Hospice service | 40% coinsurance | 50% coinsurance | ————none———— |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | ————none———— |
| | Glasses | Not covered | Not covered | ————none———— |
| | Dental check-up | Not covered | Not covered | ————none———— |

# Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-224-4902 . You may also contact your state insurance department at:

Missouri Department of Insurance
Consumer Complaints
PO Box 690
Jefferson City, MO 65102-0690
(800) 726-7390

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Missouri Department of Insurance
Consumer Complaints
PO Box 690
Jefferson City, MO 65102-0690
(800) 726-7390

(800) 726-7390
www.insurance.mo.gov
consumeraffairs@insurance.mo.gov

A consumer assistance program can help you file your appeal. Contact:
Missouri Department of Insurance
301 W. High Street, Room 830
Harry S. Truman State Office Building
Jefferson City, MO 65101

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

## About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $100
- **Patient pays:** $7,440

### Sample care costs:

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

### Patient pays:

| | |
|---|---|
| Total Deductibles | $730 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $6,710 |
| **Total** | **$7,440** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,310
- **Patient pays:** $3,090

### Sample care costs:

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

### Patient pays:

| | |
|---|---|
| Total Deductibles | $1,500 |
| Co-pays | $0 |
| Co-insurance | $1,510 |
| Limits or exclusions | $80 |
| **Total** | **$3,090** |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: call 800-930-7956 or www.medicoverage.com .

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.