Your Summary of Benefits

Anthem

CEBCO Embedded HSA Plan Option 2
Lumenos Health Savings Account

Effective 1/1/2017

Covered Benefits	Network	Non-Network
Deductible The Single deductible applies to the Family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied the benefits for the family are payable subject to coinsurance.	Single: $2,600 Family: $5,200	Single: $5,200 Family: $10,400
Out-of-Pocket Limit	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Physician Home and Office Services o Including Office Surgeries, allergy serum, allergy injections and allergy testing	20%	40%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams o Physician Home and Office Visits o Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	40%
Emergency and Urgent Care o **Emergency Room Services @ Hospital (facility/other covered services)** (copayment waived if admitted) o **Urgent Care Center Services**	20% 20%	20% 40%
Inpatient and Outpatient Professional Services Include but are not limited to: o Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	20%	40%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: o 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) o 90 days for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility o Surgery and administration of general anesthesia	20%	40%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Other Outpatient Services (Network/Non-network combined) including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% 20% 20%	40% 20% 20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical Therapy: 30 visits • Occupational Therapy: 30 visits • Manipulation Therapy: 12 visits • Speech therapy: 20 visits	 20% 20%	 40% 40%
Behavioral Health Services: **Mental Illness and Substance Abuse**[1] • Inpatient Facility Services • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility	20%	40%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	20%	40%
Prescription Drugs • **Network Retail Pharmacies:** • **Mail Service:**	 20% 20%	 40% Not covered
Lifetime Maximum	Unlimited	Unlimited

Your Summary of Benefits

Notes:

- All deductibles. Copayments and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.
- Network and non-network deductibles are separate and do not accumulate toward each other.
- Network and non-network coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26
- 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit period = calendar year
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing-limited to 82 visits/calendar year and 164 visits/lifetime

1 We encourage you to review the Schedule of Benefits for limitations.

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period: None

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 is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date