Your Summary of Benefits

MMEBG
Lumenos Health Savings Accounts (Blue Access PPO & Blue Preferred Select)
Effective July, 1 2017

HSA 1

Covered Benefits	Network	Non-Network
Deductible Non-Embedded Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $2,000 Family: $4,000	Single: $2,000 Family: $4,000
Out-of-Pocket Limit	Single: $4,000 Family: $8,000	Single: $8,000 Family: $16,000
Physician Home and Office Services Including Office Surgeries, allergy serum, allergy injections and allergy testing	20%	40%
Preventive Care Services • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening • Immunizations through age 5	20% 20%	40% 40%
Emergency and Urgent Care **Emergency Room Services** • facility/other covered services (copayment waived if admitted) **Urgent Care Center Services**	20% 20%	40% 40%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits, (1 per day) Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	20%	40%
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Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 100 days for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%

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Other Outpatient Services including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) (Network/Non-network combined) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% 20% 20%	40% 40% 40%
Accidental Dental Services $3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	40%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation 36 visits • Pulmonary Rehabilitation 20 visits • Physical/Manipulation therapy excludes Chiropractic Services: : 20 visits • Occupational Therapy: 20 visits • Chiropractic Services: 26 visits (Network) • Speech therapy: Unlimited	 20% 20%	 40% 40%
Behavioral Health Services: **Mental Illness and Substance Abuse[1]** • Inpatient Facility Services • Physician Home and Office Visits (PCP/SPC) • Other Outpatient Services @ Hospital/Alternative Care Facility	Benefits provided in accordance with Federal Mental Health Parity	40%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	20%	40%

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Prescription Drugs • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	$10/$40/$75 20% $200 max*	40%
• **Home Delivery Service:** (90-day supply) Includes diabetic test strip	$10/$100/$225 20% $200 max*	40%
Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order. Member may be responsible for additional cost when not selecting the available generic drug. Members have additional cost with retail supply greater than 30 days. **Medicare Rx - Wrap**		

Notes:

- All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance and copayment including 0%.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/ coinsurance applies.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- Network and Non-network **Deductible,** copayments, 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 deductible/copayment/coinsurance up to the maximum allowable amount. 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.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the office visit setting.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Live Health Online (LHO) is covered at the PCP costshare.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- 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.
- Benefit period = plan year
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Wigs limited to 1 per benefit period

[1] We encourage you to review the Schedule of Benefits for limitations.
[2] Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
[**] 4th Tier per script 30 day supply
*The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
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.

Your 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